FUNDING AND INCENTIVES STUDY

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COMMUNITY SERVICES STUDY

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Background Studies
Commisssioned by:
Health Care System Committee
Premier's Council On Health Strategy

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CHAPTER 1
INTRODUCTION

The Premier's Council on Health Strategy was established in late 1987 to advise the Premier and government on future directions for health and health care in Ontario. The policy recommendations of this committee are designed to take the health care system in Ontario well into the 21st century. In pursuing its mandate, the Council established four sub-committees.

One of these sub-committees, the Health Care System Sub-committee, identified the need to consider the introduction of alternative methods of funding and the use of incentives to foster new approaches to health care delivery.

To assist the sub-committee in its work, Stevenson Kellogg Ernst & Whinney was engaged to:

- Identify current funding and incentive mechanisms used for funding health care services and providers in Ontario.
- Assess the pros and cons of each mechanism from the perspective of providers, consumers, and funders.
- Determine the impact of current funding methods on the health care system.
- Identify funding and incentive options for the Premier's Council to consider, to influence Ontario's future health and health care system.

This study was prompted by an increasing concern within Ontario over the cost and direction of the health system. Discounted for size, Canada currently is second only to the United States in terms of money spent on health care. Within Ontario, health care expenditures account for a third of the provincial budget, and health care costs have increased 50% in real terms since 1977/8.

The rapidly rising cost of the health system is of even greater concern when demographic trends are considered. In common with all industrialized nations, Canada is faced with an aging population that will place increasing demands on the health care system. Canada has the second lowest population age profile of all industrialized nations. Should current trends in health expenditure continue, by the year 2011, personal taxation levels will increase approximately 2.5 times if current standards are maintained.

Another concern about the Canadian situation is our high proportion of health care delivered through hospitals of various kinds. Our country has one of the highest rates of institutionalization in the world. Community support programs, while increasing, still lag behind many jurisdictions. Expenditure on health prevention and research is low in the overall context of the health budget. Additionally, inequitable funding of providers exists.

Within the context of cost control and influencing future health delivery systems, we have identified options for the Premier's Council to consider on funding and incentives. We have reviewed the experience of other jurisdictions and surveyed initiatives undertaken in other provinces across Canada. To assist us in our work, we have collaborated with leading academics and drawn upon the experience of our health care consultants in the U.S.A., Europe and Australasia.

Professor A.J. (Tony) Culyer, Professor of Economics at the University of York, England, assisted us in reviewing initiatives in other jurisdictions. Professor Culyer is uniquely positioned to assess the relevance of these initiatives to the Ontario situation. He recently published a book for the Canadian Tax Foundation — **Health Care Expenditures in Canada.** We were also assisted in our work by Dr. Jeff Anderson, a member of the academic staff of the University of British Columbia. Dr. Anderson is both a physician and a policy analyst.

During the preparation of this report, we received valuable guidance and insights from the Health Systems Committee and the Council's secretariat. We would like to thank everyone who has contributed to our work.

CHAPTER II
HIGHLIGHTS

A. INTRODUCTION

The methods for funding the health system in Ontario are extremely complex, as are the issues facing policy makers. An analysis of the health system must examine issues that impact on consumers, physicians and service providers, such as hospitals, nursing homes and community-based programs. These issues also cross Ministerial boundaries. While the Ministry of Health the Ministry of Community and Social Services are the principal funders of health care programs, the Ministries of Housing, Education and Senior Citizens Affairs also have their part to play in the overall health system for the people of Ontario. The roles and responsibilities of each ministry and service provider need to be coordinated in a comprehensive network.

Many complex issues have to be addressed in health funding. Our report therefore is both detailed and comprehensive. To assist the reader, we have prepared a synopsis of the report in this "highlights" chapter. We have also cross-referenced our highlights section to the main body of our report, so that readers will be able to use the document as a reference source to gain more information on issues with which they are unfamiliar.

The report develops through five key chapters that describe our research:

- Chapter III provides a overview of funding mechanisms and sets out how funds are currently allocated to health care providers. It also projects the cost of the current health care system based on varying assumptions;
- Chapter IV sets out an analysis of the ways in which health care providers are paid, including hospitals and physicians;
- Chapter V contains an analysis of a number of issues and problems either currently facing the health care system or problems likely to occur unless changes are made to the system;
- Chapter VI reviews funding and incentive issues and initiatives in the UK, Sweden, West Germany, New Zealand and the U.S.;
- Chapter VII sets out a detailed analysis of funding and incentive mechanisms for hospitals and physicians together with a number of other areas that should be reassessed in terms of funding arrangements. The chapter also discusses alternative organizational arrangements.

B. WHAT ARE SOME OF THE KEY ISSUES AND PROBLEMS EXPERIENCED BY THE SYSTEM?

By most measures the province of Ontario has an excellent health care system. Generally, people receive the treatment they require in a timely and caring manner. However there are some problems on the horizon that must be addressed.

Problem area: increasing costs
A major problem within the health care system is that the rate of increase of the health care costs has exceeded the growth rate of the Ontario economy. If this continues, future health care will consume a larger and larger portion of resources in the provincial budget. This will be at the expense of other government programs.

Problem area: discordant funding systems
There is a lack of harmony within the system between the methods of payment for hospitals and that of physicians. Generally, hospitals are paid a fixed global amount whereas physicians are paid on an open-ended fee for service basis. This generates conflict both at the macro and micro levels. Doctors are rewarded for being productive whereas hospitals have to live within fixed budgets that generally do not respond to significant increases in workload.

Problem area: few incentives
The funding system provides few incentives to either providers or consumers to pursue the most cost effective method of treatment: for example, community-based programs as opposed to expensive institutionalized care. We

have not developed effective measures of outputs of the system. Hence the majority of our measures and controls relate to inputs such as the staffing levels of hospitals, drugs and equipment.

Problem area: lack of integration
The system is characterized by duplication and lack of coordination. A multiplicity of agencies, supported by government bodies, provide health and related services. The planning and delivery of these services is not always coordinated and integrated. The result is duplication of services and unrealized benefits of rationalization. Also, in some areas, there are barriers to consumer access to the service because of lack of coordination between the various providers. The planning process tends to be directed towards expansion, without consideration of replacement or substitution for existing programs.

Problem area: institutional focus
Our system has a strong traditional focus towards institutional delivery of programs. In terms of institutionalized patients, our system ranks among the highest in the world. At the same time we have almost the youngest population profile among industrialized nations. The majority of our health care dollars are directed towards health care treatment with little directed towards prevention and promotion.

Problem area: high tech health care is expensive
The health care industry has seen rapid advances in the development of high technology and capital intensive equipment. Much of this technology increases the overall cost of the system, albeit in many cases, providing better diagnosis or treatment. The effectiveness of many technological advances has not been subject to rigorous economic analysis.

Problem area: high labour costs
A further factor impacting on health care costs is the increase in real terms, of salaries and wages paid to health care workers. Canadian employees are placed much higher in the pay league than some of their European counterparts, particularly support staff.

Problem area: looking after the old and the poor
Our society is becoming increasingly characterized by a breakdown of the nuclear family. This implies that the health care system must be developed to support this aging population, providing care that will not be available through the family. Additionally, health delivery systems will have to respond to the particular needs of low income families, many of whom have single parents.

The above "problem areas" are where our present health system is experiencing problems or will face problems in the future. The funding systems and options discussed in this report provide an opportunity to resolve some of these issues. But funding and incentives will not by themselves solve all our problems. Organizational and system changes will also be necessary. It is the mandate of the Premier's Council to reflect upon existing funding and incentive mechanisms and adopt approaches that it feels would move the health care system closer to its desired goals. (Chapter V of our report expands upon the issues and problems of the current health care system.)

C. HOW DOES OUR SYSTEM WORK NOW?

A $13 billion a year operation
The Ontario health care system is a multi-billion dollar industry. Within the Ministry of Health alone, more than $13 billion is spent each year on the health of our citizens. The Ministry of Community and Social Services also provides direct and indirect support to health care. Directly, it provides such programs as community support services, the Homes for the Aged, Extended Care Program etc. In addition, the Ministry of Housing supplies support for housing to citizens who are in need. The Ministry of Education indirectly supports the health care sector as does the Ministry of Senior Citizens Affairs through its Access Fund.

A complex system

The inter-relationship of programs and Ministries results in a complicated health system. This report does not examine the funding and incentive mechanisms for every program provided by these Ministries. Rather we have focused on those areas that absorb most of the money. We were also reluctant to duplicate work that is underway in other areas. For example, the Lowy Commission is presently reviewing the Ontario Drug Benefit Program. Simultaneously with our study, community-based programs are also being examined. We have, therefore, concentrated our analysis on programs that represent about $10 billion of expenditures by the Ministries of Health and Community and Social Services. Throughout the report we discuss the implications in other areas. Clearly the adjustment of funding in the institutional areas should provide for additional thrusts in the community.

We use six different formulas for paying service providers

We explain, in Chapter IV, how Ontario has developed over the years a variety of funding approaches for its health and related social services. In general terms, the various funding approaches can be described as follows:

- **Global funding** — generally applied to public hospitals, with a global envelope of funds, adjusted each year for inflation, new programs and growth, with no automatic settlement made at year end;
- **Modified global funding** — generally applied to private hospitals and children's treatment centres in which there is a year-end settlement back to the total global amount;
- **Cost reimbursement** — a less-used form of funding wherein the province reimburses actual costs incurred, notably applied to Ontario's 10 psychiatric hospitals;
- **Fee-for-service** — a payment system based on a rate or fee per unit of service provided, notably applied to physicians and to nursing homes (Extended Health Care Plan);
- **Ex-global formula funding for specific cost items** — most notably applied to public hospitals for increased patient activity, life support programs, growth and some specific high-cost diagnostic equipment;
- **Ex-global actual cost reimbursement** — to public hospitals for approved new and expanded programs.

Our systems for funding have two major objectives:

- First, to optimize consumer satisfaction and provider ability to maintain service quality;
- Second, to keep health expenditures at a reasonable proportion of the provincial budget.

This balance has been very difficult to achieve. Over the past 30 years, a number of significant alterations have been made to reimbursement systems. Indeed, some form of "exception to the rule" funding adjustments have had to made in every fiscal year. Clearly, significant amendments are again needed to Ontario's health and social funding systems to assure the ongoing provision of services at desired levels, of both quantity and quality.

D. WHAT CAN WE LEARN FROM OTHER COUNTRIES?

To see if we could learn something useful from other people's experience, we reviewed health-care financing in other countries. Our findings are detailed in Chapter VI. Key points we have identified:

- In Canada, some provincial governments presently put limits on total payments to the province's physicians. The fee-for-service (FFS) system is maintained but the overall billings to the system are capped at a certain level. The FFS mechanism is used to influence the geographic distribution of physicians. For example, doctors in Quebec are

paid above scale for practising in under-doctored rural areas, whereas physicians in over-doctored urban settings are paid below scale;

- The United Kingdom and Sweden have established regionalized health agencies. This facilitates the coordination of health development in the broader sense, and brings resource allocation decisions closer to the consumer — and to local needs and priorities;
- The UK has a parallel private hospital sector. Approximately 10% of the population is covered by private health insurance. This has introduced a two-level health care system in terms of access to the system for elective procedures and comfort of hospital surroundings;
- Sweden has developed a salary system for its physicians. This provides a control over total payments to physicians. However, the productivity of physicians in Sweden is extremely low by international standards;
- Case-mix-funding systems in the United States have tended to reduce the length of inpatient stay. The number of acute patient days per thousand of population in the United States is approximately 900 compared with more than 1,200 in Ontario. Inpatient costs, controlled by case-mix-funding mechanisms, have fallen. In contrast however, the cost of ambulatory care (not regulated by case-mix-funding) has increased;
- West Germany allows its citizens to choose their own health care insurance coverage once they have reached a minimum salary level. All other insurance is paid by employers. This covers 100% of the costs of required health care;
- The United States lacks universal health care coverage. Approximately 37 million Americans have no health insurance;
- In the UK a regionalized system of resource allocation, based on age, morbidity, and population (the RAWP formula,) is helping to achieve more funding equity.

In its selection of alternatives and options for the Ontario health system, the Premier's Council should be aware of those components that are now successfully operational in other jurisdictions. The success of these operations should be weighed against the issues and problems within the Ontario system and the needs of the Ontario society, to determine the efficacy of implementation in Ontario. One must not assume, however, that what "works" in another country would work equally well here in Ontario: health funding systems, by their very nature, have a pronounced "cultural content."

E. WHAT ARE THE ALTERNATIVES?

1. Three key areas

As a result of our review, we have identified three high-priority areas that require attention from the Premier's Council on Health Strategy. These are:

- The myriad of linkages between providers and the provincial government;
- Physician funding;
- Hospital funding (operating and capital).

Other areas of concern are research funding, source of funds, prevention and promotion, consumer choice, and community care funding. Our analysis of these issues is set out in detail in Chapter VII — we summarize below the key alternative funding and incentive mechanisms for this area.

2. What are the alternatives for linkages to Queen's Park?

A key feature of current organizational linkages in the health system is the enormous number of hospitals, agencies and other providers that have direct linkages with the provincial government. The integration of the constituent elements of the health care system takes place at Queen's Park, an organizational level far removed from the delivery or consumption of the services the provincial government finances.

- **Decentralization**
  The management of health systems around the world is becoming increasingly decentralized. Service delivery models are emphasizing vertical and horizontal integration of services, focussed on specific client groups in one-stop access programs. Strong arguments can be made for decentralized management through regional organizations that would facilitate integration and avoid duplication.

  Several options are available to policy makers wishing to increase local control over resource allocation decisions and improve service integration. One option is the establishment of Local Health Agencies (LHA), an organizational arrangement common to a number of European countries and being developed in New Zealand. LHA's could be the funding and planning agencies for both institutional and community-based programs. This organizational arrangement is not the addition of a bureaucratic tier between central government and providers, but more a delegation of responsibilities, particularly local resource allocation.

- **Integration**
  Another option is the establishment of Comprehensive Health Organizations (CHO), a service delivery model currently being tested by the Ministry of Health. In many communities, hospitals are the focal point of health delivery. Hospitals have the management depth that would allow them to manage a broader portfolio of local services. The integration of community-based and institutionalized health care into one management unit would facilitate service integration and reduce inter-agency competition through Queen's Park for limited resources. A variation of the CHO would be to broaden the sphere of responsibilities of selected hospital boards and with it the role of the hospital. Or, District Health Council's might be reconstituted with a more operational role.

3. What are the alternatives in physician funding?

Throughout the world physicians are paid in three major ways. These are:

- Fee for service;
- Capitation;
- Salary.

Within these major categories a number of incentives might be used to control costs while maintaining the physician's ability to provide the high quality of service deemed essential for patient care.

Physicians are the key controllers in the health care system. Their payment mechanisms, therefore, must be structured to ensure that provincial health policies are met. Each payment mechanism has some features that are consistent with provincial objectives. However, each payment mechanism also has features that are at variance with provincial goals and need to be modified.

For example, fee-for-service mechanisms reward productivity but would have to be modified to encourage, say, prevention and health promotion. Capitation payments encourage de-institutionalization but may restrict people's access to doctor's services. Salaries provide effective financial control but do not ensure productivity.

Maintenance of a high quality of care must go hand in hand with incentives. Quality of care goes beyond the quality of a specific clinical intervention. It must also ensure that the most appropriate intervention takes place. More care is not always synonomous with better care. Merit awards, administered by peer group reviews, are an option to consider in the quality assurance process.

It is not necessary to have one particular system for all physicians, in all parts of the province. A mixed compensation system

might be developed that would bring together the needs of both physicians and government. There could be separate systems for academic physicians, family practitioners or specialists. There could also be specific mechanisms for paying physicians in different geographic areas and urban environments. Regardless of the system selected, the incentives have to be based on the goals that the province wishes to achieve.

4. What are the alternatives for hospitals?

i) Operations funding

Since 1969 Ontario hospitals have been funded primarily on a global budgeting system. Hospital expenditures have been relatively stable in real dollar terms compared to GPP. The global budgeting system is relatively simple to manage and provides effective cost control. However, hospitals argue that significant inequity has developed between the funding levels of various hospitals. There is a discordancy between the methods of funding hospitals and of physicians. We need to develop incentives that promote the movement away from the present heavy emphasis on institutional care.

Within the industry a number of alternative payment systems are available for hospitals:

- An itemized payment of service — under this system hospitals are reimbursed for each and every service provided. This system tends to be administratively complex and does not provide effective cost control. However, it does provide detailed information on services provided to the patient;
- Daily charges — under this system, hospitals are reimbursed for each day of care given to patients in the hospital. The system is somewhat simpler than itemized service payments as it does not require a detailed information bank on services provided to patients. This system provides incentives for controlling per diem rates. However, daily charges embody no inherent incentives to improve utilization and reduce length of stay;
- Case payment — under this system, hospitals are reimbursed for each admission. The admissions are weighted by case complexity. This system provides direct incentives to control both per diem costs and utilization for patients admitted to the hospital. However, there is little control on the level of hospitalization of patients and it does not cap total expenditures;
- Capitation — under this system, the hospital is prepaid a capitation rate for each resident within a service area. This system has incentives for controlling costs, utilization, and hospital admission rates. It may, however, restrict consumer access to service. The administration of a capitation system might require linkages with HSOs or CHOs to be effective.

Policy makers are faced with a dilemma. On the one hand, if productivity and consumer access is to be encouraged, fee-for-service mechanisms are appropriate. But without additional controls, the arrangement has proven to be very costly. On the other hand if real cost control is to be achieved the capitation system is appropriate, provided mechanisms to ensure consumer access to the services are in place.

The hospital funding system for Ontario can be modified by moving from the present global funding system and implementing one or a combination of the payment mechanisms described above. Alternatively the global budget system can be maintained and adjusted on an annual basis. If the global funding system is maintained, present inequities in the

system need to be corrected. This could be done by providing all marginal annual rate increases at the peer group mean and/or giving priority to new program developments in lower-cost hospitals.

Ontario stands out in its reliance on institutional care. A major challenge is to find ways to reduce this dependence and to develop community-based services. As well, reimbursement techniques for hospitals should provide incentives to move people from institutional care to less costly community-based programs.

II) Capital funding

Hospitals have voiced a need for more money for capital redevelopment than the government can afford to supply. In addition, in the life cycle of a hospital, capital construction costs may represent only 2% of the overall health care costs. In other words, the operating costs associated with redeveloped hospitals are very significant.

In 1986 the Ontario government committed $850 million for the development of 3600 additional beds. We understand that the cost of these commitments has escalated to perhaps double the original estimate. At the same time, developments have taken place in the health care field that increase the emphasis on ambulatory and community-based programs, reducing the need for institutional care.

Many hospital accommodation studies indicate that about 10% of acute care beds and 25% of chronic care beds are occupied by patients who should be placed elsewhere. Many patients are placed inappropriately in high cost facilities whereas their true needs are for less intensive care. In the United States the dependency on acute care beds is approximately 25% lower than in Ontario. We believe that the plans to add additional acute and chronic beds to the system should be delayed until such time as the true bed needs of the province are established. There could be significant cost savings as the operating and capital costs for extended care facilities are signficantly lower than for chronic or acute care beds.

However, some capital investments cannot be postponed. For example, developments that ensure fire codes are met, and potential future hazards are avoided, must continue. Also, capital developments that can reduce operating costs should be considered immediately. A priority system for capital investments should be developed to assist in the approval of capital expenditures.

5. What are the other funding issues?

We have described the major areas for funding and incentives that should be considered by the Premier's Council. However, a number of other areas also deserve consideration:

I) Research funding

In Ontario we spend less than 1% of our health care costs on research. The United States spends more than 2%. The health care system in Ontario will be faced with many serious choices in the foreseeable future. Policy formulation, decision making and alternative program selection must be well researched with objective data. Funds for new programs are limited and competition is intense for new money. We must ensure that the implications of new programs are thoroughly researched and understood before implementation. A number of areas require further research. These include:

- The cost impact of community care;
- The cost impact of new technology;
- The overall bed requirements for the province;

- The development of outcome measures for the system;
- The impact on quality of care of different methods of funding;
- The development of public education programs to enhance patient choice;
- The viability of prevention and promotion programs and the cost impact to society.

II) Sources of funds

This report deals mainly with the methods to dispense funds within the health system to provide and maintain a high level of quality service in a cost effective manner. The attempt is to manage the growth and redistribute the funding in the most cost effective manner. Once this redistribution has been completed, we will be in a better position to determine whether more funding is required or whether a redistribution of the source of funds should be considered. Some of the choices might include:

- Chronic co-payment charges to all chronic patients regardless of their present placement;
- Restriction of OHIP premium exemptions and drug benefits to those who truly cannot afford to pay;
- Allowing controlled development of private hospitals as in the United Kingdom, New Zealand and the United States;
- Charges to consumers e.g., for "hotel" services, alternate choice meals, etc.;
- A full-cost insurance system for health care coverage.

III) Prevention and promotion

Disease prevention and health promotion have evolved into two distinct concepts.

Disease prevention can be categorized as primary, secondary, or tertiary. The purpose of primary prevention is to prevent the occurrence of disease through the identification and modification of risk factors. Primary preventive health services encompass interventions such as immunization, counselling, and family planning. The purpose of secondary prevention is to detect and treat disease early so that the patient is cured or the disease progression is slowed and/or complications prevented. Secondary preventive services include interventions such as screening programs. Tertiary prevention is often seen as disease treatment and rehabilitation aimed at limiting disability or restoring functions.

In the early days, health promotion was seen as something that promoted and encouraged people to adopt healthy lifestyles, which then meant observing good nutrition and personal hygiene and being physically fit. In recent years, health promotion has come to be defined much more comprehensively. The World Health Organization's definition is:

"health promotion is the process of enabling people to increase control over, and to improve, their health. It represents a mediating strategy between people and their environment, synthesizing personal choice and social responsibility in health to create a healthier future."

Inequities in health and health opportunities are a major issue in health promotion. Despite the many advances of our health care system, people's health remains directly related to their economic status. The challenge we face is to reduce inequities in the health status of low income groups.

A substantial amount of work has already been completed in terms of reviewing health prevention and promotion in

Ontario. However, further research is required to determine the efficacy of prevention and promotion initiatives.

iv) Consumer choice

The monopolistic provision of health by the government, while providing universal access to patients regardless of income, is inherently restrictive. The virtual absence of a private sector in Canada provides no alternatives for consumers. Health care workers have little choice other than working for government-funded organizations. Most European countries have some private sector provision of health care and even in state-funded systems such as the UK's National Health Service, private-sector options are available to the consumer.

Consumer choice is further restricted by funding and resource allocation methods. For example, consumers cannot choose to use their health care tax dollars to purchase home care services that might avoid hospitalization. The choice is made for them by health care professionals during the resource allocation process. One mechanism for increasing consumer choice is a voucher system that would entitle holders to purchase services from their preferred providers. The flow of increased private sector funds into the health sector would also stimulate competition, and work towards ensuring that service provision reflects consumer demand.

v) Community-based programs

Our health care delivery is too institutional. We should be directing more funds to community-based programs. The amount of funding allocated by the Ministry of Health to community programs is about 5% of its total funds. However, this percentage does not include the community-based care provided by physicians or the ambulatory care program delivered by hospitals.

Throughout this report we have identified mechanisms to move toward community care. Organizational changes, and changes in funding physicians and hospitals, are required to reduce our dependency on institutional care.

F. PRINCIPLES GOVERNING A FUNDING SYSTEM

The reactive, as opposed to proactive, history of Ontario health care funding has obscured the essentiality of key principles governing important issues such as equity, quality, cost and freedom of consumer choice.

The funding system in Ontario, as in many other jurisdictions, has developed through a series of ad hoc arrangements. As a result, our present situation exhibits inconsistencies and anomalies. For example, the fee-for-service, open-ended nature of payments to physicians under the Ontario Health Insurance Plan and the Global Funding System of hospitals have inherent contradictions. The various methods of funding capital costs are inconsistent —and hard to rationalize since they do not always emphasize the shape of the health care system that the government and others wish to have.

Changes to the health care system can be facilitated by two major tools. The first tool is through changes in legislation or regulations. In this way providers and consumers can be mandated to perform in a certain way. The preferred tool is to adjust funding and incentives to move the system in the appropriate direction. This report deals with changes through this mechanism.

This study is an opportunity for the Premier's Council on Health Strategy to reassess the present funding systems and to recommend changes to better meet the needs of Ontarians. Paramount in all of this is the need to ensure that high quality care is provided. The funding system alone cannot do this. However, without the appropriate incentives and funding arrangements we may not be able to preserve existing quality without massive increases in funding (and also taxation.) The government alone can make such decisions. However, we sense that cost increases of the magnitude we have projected could seriously distort priorities within our society without commensurate improvements in the health of our population.

Decisions about funding of the various components of the health care sector should not be made in isolation from each other. The interdependencies of the system have to be recognized. And the thrust towards services outside institutions must be reflected in funding arrangements and incentives that make sense to all concerned.

One consequence may well be the development of different organizational structures and linkages. We see merit in allowing for local differences, if this can be accommodated within overall government guidelines and funding policies. A diversity of organizational structures and linkages at a local or regional level can be a strength. Hopefully, a number of such pilot projects can be arranged over the next few years.

From a funding perspective, therefore, we believe that there could be advantages in having local choice about how specific components of the system are put together. However, this should be accomplished within a framework of an overall funding system that ensures equity and balance across the province as a whole.

The provincial funding system should therefore embrace the following six principles:

1. Equity

The system should ensure equity in funding and service levels across the province. In other words, a resident of northern Ontario is as entitled to health care services as a resident of Toronto. However, one cannot reasonably expect that all of the health care services presently available in Toronto should be available everywhere in the province. But the funding system should certainly permit the individual from northern Ontario to freely access the services required for optimal health care without geographic location being a limiting factor.

We have pointed out a number of ways in which equity can be ensured — for example through an allocation of funds on a capitation basis to some local organization such as a health service organization, a comprehensive health organization, or a local health agency.

2. Quality

The second major goal in the health care system is the maintenance or improvement of quality. "Quality" has broad implications. We have very few objective measures of it. In many cases, it is the cumulative judgement of the professionals within the system that ensures that change has a positive impact and quality. Many of the alternatives suggested in this report have the potential of adjusting quality. Within some forms of funding, patient access is enhanced and quality should be enhanced as well. However, it can be argued that incentives that ensure easy patient access have the potential for over-servicing of patients. Over-servicing can have as many negative impacts on quality of care as under-servicing. With some forms of funding, the incentives are to reduce the patient contact with the system. We must be very careful that this apparently positive incentive from a cost perspective does not result in under-servicing of patients in need.

Quality of care is one of the successes in health systems. Ontario probably meets this test as well as any other jurisdiction in the world. So the cost pressures that urge reforms on us require a skillfully modulated response.

3. Harmonization of funding systems

The various components of the health care sector should be harmoniously funded. In other words, the rules for funding one component of the system should not be at odds with those for funding other, related parts of the system.

4. Balance

There must be a balance in the money allocated to various components of the system. Currently we over emphasize in-patient care and have not fully developed ambulatory and community programs.

Many hospitals are already running community based programs and this role could be expanded. However, we are concious of the concern that many community groups have over the power and "hospital-based" focus of some of these programs.

As we mentioned earlier, precise organizational arrangements at the local level should not be copied from a template decreed by Queen's Park. Equally, given the availability of overall provincial guidelines, the Ministry should be able to count on local people to ensure that the high quality care they expect is provided in the most appropriate way for their community.

5. Incentives

We clearly need to develop incentives for cost control. In the example quoted above, many hospitals would be more than ready to rechannel their resources to help provide ambulatory and community care services if they had the incentive to do so. Equally, we could visualize cooperative arrangements between community-based groups, hospitals and physicians in whatever organizational structure or linkages make most sense to them.

Incentives should be designed to achieve the overall goal of the system — which currently we perceive to be directed towards the development of non-institutionally based services, and synchronization of activities amongst the various players in the system.

Incentives should not only be in place for organizations. Within organizations themselves, certain incentives might also be considered to harness the energies and drive of people at various levels in the system. Incentives to consumers should also be considered.

6. Choice

Choice is important. We want to avoid a rigid, structured system that would depersonalize the care we now receive. At the same time, we cannot set the existing system in concrete and regard it as unchangeable. What seems to be important is to allow consumers to have choice over how they will receive services and how they will pay for them. Certainly we should not forget the providers of health care services. They should be stimulated to look at new ways of providing health care and also, we believe, alternative ways in which they may be fairly compensated for the services they provide.

Other key principles may be developed as discussions continue about the restructuring of the way in which the health care system is funded. However, an integrated application of the six principles noted above would go a long way towards helping those who must design a new system to ensure that it meets the changing needs of our society.

CHAPTER III
SOURCES AND USES OF HEALTH CARE FUNDS

A. THE TWO MAJOR DIVISIONS OF ANALYSIS

Evaluation of the funding of a health care system clearly calls for two major divisions in the analysis:

- First, the mechanisms for raising the funds and the related sources of these funds;
- Second, the methods by which health care funds are allocated within the system.

The roots of this study lie in the sharpening conflict between sources and allocation: as matters now stand, the financial appetite of the system is outrunning the government's ability to finance it without major shifts in fiscal priorities in future years.

B. HISTORICAL OVERVIEW

Ontario started its hospital insurance plan in 1959, with two prime funding sources, namely, the hospital insurance premiums paid by insured Ontario residents, and federal government cost-sharing under the Hospital Insurance and Diagnostic Services Act. Originally, provincial and federal shares were to be equal — 50:50. Since that time, many additional programs have been brought in and funded in whole or in part by the Ontario government. Also, significant changes have taken place in the federal government's method of sharing health care costs. Today, the federal government does not make transfer payments to provinces under a strictly health-care umbrella. Rather, federal sharing payments for health and post-secondary education are made under the Established Program Financing Act. The funding provided under this act is on a funding base from the time this legislation was passed, with an escalator formula to provide for annual increases.

In today's multi-program health system in Ontario, the source of funds has shifted dramatically — with approximately 15% of costs being supported by the Ontario Health Insurance Plan premiums, plus 46% from general provincial revenues, and the balance of 39% coming from the federal government through EPF arrangements. This change, since 1959, has placed a significantly greater burden on the Ontario tax revenue base than was felt, or contemplated, in the late '50s and early '60s.

It is also important to note that the Ontario Hospital Services Commission was the receiver of both the hospital insurance premium revenue and the federal government's hospital funding. Within these two sources of funds, the Commission was expected to contain payments to hospitals. In the event of a shortfall, the Commission had to make its case to obtain funds from the general provincial revenues. In today's system, the Ministry of Health is not a receiver of funds, but rather, has funds allocated to it through program votes by the provincial legislature. The estimates process involves approval at a number of levels, including Management Board of Cabinet, Cabinet, and the legislature through its Standing Committee on Health and Social Services. Finally, funds have to be voted by the legislature itself. In other words OHIP has been disconnected from its original pivotal role in the funding of Ontario health care.

C. HOW THE FUNDS ARE CURRENTLY ALLOCATED

As we explain in Chapter IV, Ontario has developed over the years a variety of funding approaches for its health and related social services. Most of the complications involve changing ways of funding public hospitals in the province. In general terms, the various funding approaches can be described as follows:

- **Global funding** — generally applied to public hospitals, with a global envelope of funds, adjusted each year for inflation, new programs and growth, with no automatic settlement made at year end;
- **Modified global funding** — generally applied to private hospitals and children's treatment centres in which there is a year-end settlement back to the total global amount;

- **Cost reimbursement** — a less used form of funding today wherein the province provides reimbursement of actual costs incurred, notably applied to Ontario's 10 psychiatric hospitals;
- **Fee-for-service** — a payment system based on a rate or fee per unit of service provided, notably applied to physicians and to nursing homes (Extended Health Care Plan);
- **Ex-global formula funding for specific cost items** — most notably applied to public hospitals for increased general patient activity, life support program growth and some specific high-cost diagnostic equipment;
- **Ex-global actual cost reimbursement** — to public hospitals for approved new and expanded programs.

Exhibit III-1 shows the distribution of Ontario health care expenditures by type of funding and service provided.

Ontario applies two principles in its funding and reimbursement systems for health care. The first is to optimize provider satisfaction and provider ability to maintain quality and quantity of service. The second is to control government transfer payments within available provincial funds. This balance has been very difficult to maintain. Over the past 30 years, a number of significant alterations have been made to reimbursement systems. Indeed, some form of "exception to the rule" funding adjustments have had to be made in every fiscal year. Clearly, significant amendments are again needed for Ontario's health funding and incentive systems to assure the ongoing provision of services at desired levels of both quantity and quality.

EXHIBIT III-1

Distribution of Ontario health care expenditures, by type of funding, 1987/88 (est.)

Type of funding	Funds ($ millions)	Per cent total
Global		
Public hospitals	5,100.0	42.9
Cancer Treatment and Research Foundation	52.0	0.4
Ontario Cancer Institute	40.9	0.3
Addiction Treatment and Research Foundation	29.0	0.2
Private hospitals	28.0	0.2
Child treatment and rehabilitation centres	18.9	0.2
	5,268.8	44.3%
Fee for service		
O.H.I.P • Physicians	2,920.0	24.6
• Others	680.0	5.7
Ontario Drug Benefit	537.0	4.5
Nursing homes	346.0	2.9
Homes for the aged1	275.0	2.3
Homes for special care	88.0	0.7
Out-of-province/country	94.9	0.8
Assistive devices	23.7	0.2
	4,964.6	41.7%
Cost reimbursement —line-by-line review		
Provincial psychiatric hospitals	293.0	2.5
Home care programs2	207.7	1.7
Public health	289.0	2.4
Ambulance services2	155.9	1.3
Community mental health programs	65.0	0.5
Red Cross Blood Service	46.0	0.4
Community health	43.6	0.4
Clinical education	156.9	1.3
Hospital capital program	221.0	1.9
Provincial labs	25.3	0.2
Other programs	157.0	1.3
	1,660.4	14.0%
TOTAL		**$ 11,893.8**
100.0%		

Source: Ontario Ministry of Health

1 This program is managed through COMSOC.

2 Individual providers may be funded on a fee-for-service basis.

D. FUTURE HEALTH EXPENDITURE

To provide an understanding of the future direction of Ontario's expenditures on health, we prepared projections of Ministry of Health expenditure, under two scenarios, to the year 2011. We also carried out a literature survey in order to establish the key factors that will impact on the future levels of health care spending. We have set out in Appendix A extracts from our literature survey. The main factors affecting future Ministry of Health spending are as follows:

- Increase in the overall size of the population;
- Increased utilization rates for hospital and physician services particularly by the elderly;
- Increasing costs per unit of service.

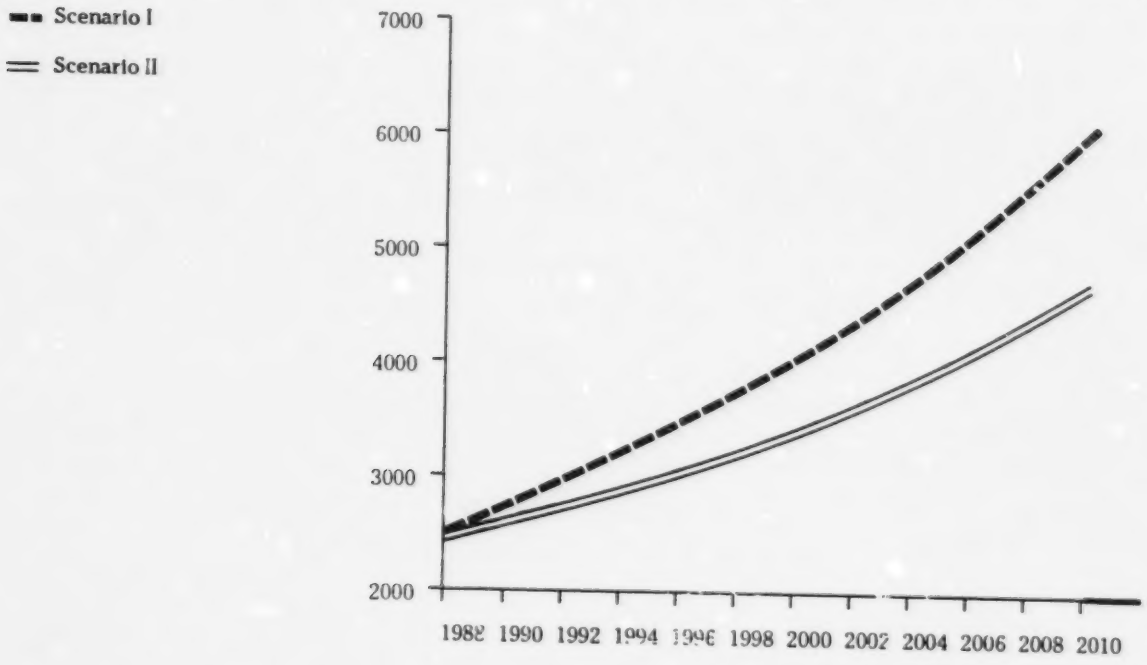
Taking into account the key factors influencing health care expenditures, we examined historical Ontario data and projected future Ontario Ministry of Health spending. We used a methodology comparable to that used in an article in the *Canadian Economic Observer*, "Can we afford an aging society?," written by Dr. I.P. Fellegi, head of Statistics Canada. This projection calculated the "affordability" of increasing health care expenditures by relating them to the number of "taxpayers" in the labour force for the 20-64 age group. In particular, we identified labour force participation rates as a factor to consider in the affordability of health care costs.

The assumptions on which our projections are based are set out in Appendix A.

We projected two scenarios. Scenario I uses the most current five years of data. We see on the following exhibit (III-2) that total Ministry of Health costs per "taxpayer" will increase from $2,394 in 1988 to $6,125 by the year 2011. This represents an increase of more than 2.5 times over the 23-year period. Scenario II, uses data from the most recent ten years, and projects a similar increase to $4,793 per "taxpayer" by the year 2011. This still represents an increase of approximately 2 times in real costs per "taxpayer" over the 23-year period.

EXHIBIT III-2

Total Ministry of Health cost per "taxpayer" — in constant 1984 dollars



Increasing cost per unit of service is the major cause of increasing costs per "taxpayer". For example, as shown in Exhibit III-3 under Scenario I, the increase in absolute population between 1988 and 2011 would increase total Ministry of Health cost per "taxpayer" from $2,394 to $2,441 — an increase of 2.0%.

If we add increasing utilization rates into the projection, we see an increase in total Ministry of Health costs per "taxpayer" from $2,394 in 1988 to $3,815 under Scenario I.

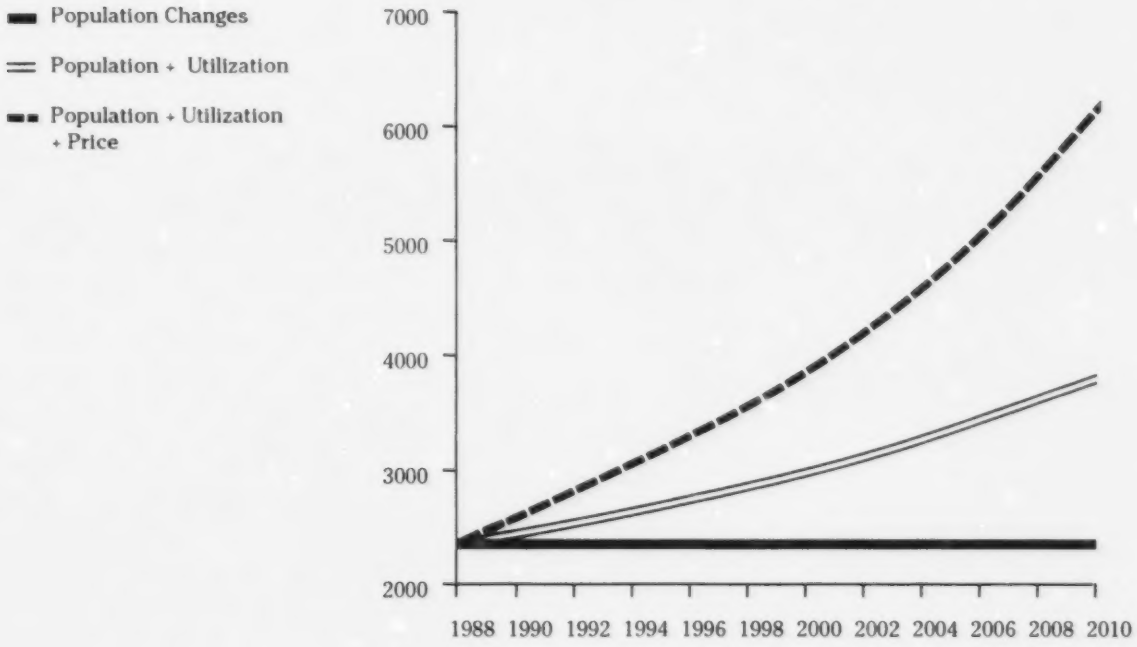
Finally, if we add cost per unit increases into the projection, we get the final result of an increase from $2,394 per "taxpayer" in 1988 to $6,125 by 2011 — an increase of 2.5 times the 1988 costs.

Clearly the most significant factor contributing to the total Ministry of Health cost per "taxpayer" increases is the increased cost per unit of service. These increased costs per unit of service are a result of a number of factors, including:

- Increased real salary rates for health care workers and the reimbursement of physicians;
- Increased use of expensive high technology;
- An increased number of interventions per hospital day or physician visit;
- Increased intensity of resource use or interventions because of changing medical practices and case complexity.

EXHIBIT III-3

Total Ministry of Health cost per "taxpayer" in costant 1984 dollars — scenario I



The foregoing analysis, based on a limited number of factors that impact on health costs, provides some indication to the future costs of the health care system. The analysis does not constitute a full econometric model. Nevertheless, even this simple analysis does demonstrate clearly the problem confronting our health care system. The burden on the taxpayer for health care will increase exponentially, or the quality of our system will degrade significantly, unless we change the present trends. The cost increases are caused by three factors: increased population size, increased utilization and increased price. The first factor is given and cannot be changed. However, it has the least impact on costs. Utilization is caused by a contribution of factors including such things as more aggressive treatment and new treatment methods. Therefore some of these factors can be controlled. The other factor, price, is controllable and represents the greatest impact on the total cost. Our mandate is to understand and control these prices and utilization while maintaining our quality of care.

CHAPTER IV
FUNDING MECHANISMS IN THE ONTARIO HEALTH SYSTEM

The Government of Ontario, primarily through the Ministry of Health and the Ministry of Community and Social Services, has administered a wide range of health and social service programs for many years. These programs are delivered through institutions, community services and on a personal basis. The funding reviewed in this chapter relates to the following:

- Public hospitals;
- Private hospitals;
- Children's Treatment Centres;
- Psychiatric hospitals;
- Community psychiatric services;
- Nursing homes and homes for the aged;
- Physicians;
- Drug benefit plan;
- Home care service;
- Public health.

A. PUBLIC HOSPITALS

1. Funding was originally on a line-by-line cost-reimbursement basis

From the start of publicly funded health insurance in 1959, to 1969, public hospitals were funded on an actual-cost-reimbursement basis. The funding levels were determined at the beginning of each year based on a line-by-line review of the hospitals' budget submission. The year's final funding level was settled at year end, based on a line-by-line review of the actual results as reported on its audited financial statements. The line-by-line review was marked by two major difficulties:

- The difficulty of establishing a standard costing level for a given item of expense from one hospital to another. Obviously, without some form of standardization, arguments over funding allowances would be frequent;
- The difficulty arising from the fact that a hospital was not permitted to transfer funds from one line item of expense to another. Often a hospital could find ways to reduce the budgeted expense level of, for example, food, but required additional dollars for another expense item, for example, drugs. Such a switch in line-item funding could not be made without government approval.

The predictable outcome of these two major difficulties was a growing number of appeals for approval to switch funds from one line item to another, and for more funds, overall.

2. Global funding was introduced in 1969

In 1969, recognizing that hospitals needed increased flexibility for management decision-making, the Ministry of Health introduced global funding. Simply stated, this meant that each hospital now received a global envelope of funds equivalent to its previous year's final funding level plus a percentage increase to reflect inflation. The hospital was given the authority to allocate the global envelope of funds across its programs and expense items as it deemed appropriate, on the general conditions that services would not be expanded or reduced without approval, that service quality would be maintained, and that additional funds would not be requested.

At that time, in 1969, no fundamental changes were made to the hospital statistical and financial reporting systems. As in the previous 10 years, hospitals were required to continue to submit an operating budget at the beginning of the year, monthly operating reports, year-end statistical and financial reports, and audited financial statements. Also, no change was made to the fundamental practice of requiring a year-end settlement, except that the settlement was now made back to the total global funding amount, rather than a settlement on each specific line item of expense.

With the change to global funding, the government essentially resolved the difficulty inherent in hospitals being unable to switch funds from one line item to another. Experience showed, however, that difficulties

continued in the overall matching of total spending with total funds available. In each of the years beginning in 1969, many hospitals made appeals for additional funding. Typically, these appeals came at one or more of three junctures:

- The operating budget would be submitted showing a "net allowable operating cost" or a "net Ministry liability" higher than the amount that had been approved as the global funding level for the hospital for the coming year;
- In-year appeals for funds either contained within the regular monthly operating report or contained in a separate ad hoc written appeal;
- Year-end requests for additional funding.

3. **Increased workload played a key role in appeals for more funds**
The discussions between the Ministry of Health officials and the hospitals with respect to these appeals for additional funding essentially revolved around the degree to which both sides could come to an agreement on one or both of two questions:

- First, should additional funding be made available for cost increases associated with increased patient workload?;
- Second, should additional funds be made available to cover increased unit costs, that is, higher cost of producing the same number of units of service as had been budgeted?

Increased caseload was ultimately accepted as an argument for increased funding. There was more difficulty in resolving funding requests for higher costs for the same level of workload. Here, increased costs were brought about by more staff or supplies purchased, or an increase in wages or prices or both. Hospitals were expected to strive for greater efficiency to offset such costs beyond the level deemed to be covered already in the annual funding increase.

4. **Changing case mix was not addressed**
During the early part of the global funding years there seems to have been little consistency in the manner in which caseload growth, and its attendant incremental cost, was dealt with from a funding point of view. Also — and perhaps of more far reaching importance — little attention was given to the underlying causes of cost increases not strictly related to caseload increase (e.g., more inpatients or outpatients), but rather the result of case-mix and case-management changes in the hospital. Indeed, this critical set of causal factors has yet to be addressed and dealt with adequately.

5. **1979: the Committee on Hospital Resource Allocation and Budgeting**
In the period since 1969, increases in occupancy levels had been forcing hospitals to try to reduce "length of stay" and to tighten admission criteria. As a result, diagnostic case-mix changes occurred: many hospitals —particularly those providing secondary and tertiary care — found themselves dealing with a patient population whose care was becoming more and more costly to deliver. Also, during the 1970's, hospitals were experiencing rapid changes in diagnostic and therapeutic techniques. Many new technologies were being introduced. As the decade of the 1970's progressed, it became increasingly obvious that more far-reaching adjustments would have to be made to the province's system for funding hospitals. In 1979, the Committee on Hospital Resource allocation and Budgeting (COHRAB) was established with a mandate to review current hospital funding practices and recommend changes that would address the issues of growth and increasing diversity within the hospital system.

In June 1980, COHRAB produced recommendations that were to become the foundation of the hospital funding system as it is today. Most notable:

- That hospitals be permitted to retain at least a portion (60%) of any annual surplus;
- That small hospitals be given an additional percentage increase in annual funding to recognize smaller economies of scale and fewer opportunities to increase efficiency because of their smaller size;
- That funding adjustments be introduced for caseload growth;
- That funding adjustments be introduced to recognize the cost of more special life-support programs;
- That the Ministry of Health enter into a contract with each hospital setting out the type and scope of services to be provided.

With the exception of the contract recommendation, all the other recommendations were implemented as stated, or with modification. One of the most significant recommendations, regarding retention of surplus, was implemented but the government decided to allow hospitals to retain 100% of any surplus earned in a fiscal year.

In the two years following the COHRAB report, a number of significant changes were introduced in the government's approach to the funding of hospitals:

a) Life-support funding

In December 1981, the Minister of Health announced that he was requesting that the Ontario Hospital Association (OHA) and the Ontario Council of Administrators of Teaching Hospitals (OCATH) join with the Ministry of Health to establish a tripartite committee on life-support program funding, to develop guidelines for future growth in life-support programs in hospitals, and to establish a formula for funding the incremental costs of this growth. The following guidelines were established:

- Life-support funds will be provided to designated hospitals providing the following services:
  - neo-natal intensive care;
  - total parenteral nutrition (TPN);
  - oncology/chemotherapy;
  - cardio-vascular surgery;
  - pacemakers;
  - end-stage renal disease;
- Life-support funds would be channelled only to hospitals designated as those approved to provide one or more of the life-support programs;
- Hospitals would be designated by the Ministry upon advice from District Health Councils or other local planning bodies in the absence of a District Health Council;
- Only the incremental direct costs related to the growth in a life-support program activity would be considered for funding assistance.

In 1986/87 pacemakers were dropped as a life support program because the caseload had levelled off. In its place, intra-ocular lens inplants were introduced as a life support program.

Also added in 1984/85, as a life support program, were the costs related to the use of the immuno-suppressent drug cyclosporine. Approval had been given for a small number of designated hospitals to use cyclosporine as an anti-rejection agent in solid organ transplant cases.

Over the last five fiscal years 1982/83 through 1986/87, a total of $65million has been allocated to designated hospitals to contribute to the incremental costs associated with growth in life-support programs.

Allocation for funding for fiscal 1987/88 is currently being finalized and it is expected that the total will be approximately $17million.

Also under the general life-support funding heading, the Ministry/OHA/OCATH Tripartite Committee has been asked to deal with the allocation of an additional $9.5million to assist hospitals with the incremental costs of switching from ionic contrast media to non-ionic contrast media. This affects for the most part medium to large hospitals.

b) Workload growth

The Ministry of Health recognized that increases in inpatient and outpatient caseload could result in added cost to hospitals. The funding formula was developed in conjunction with the OHA and OCATH. Essentially, the formula is based on the increase in equivalent patient-days (EPD) from one year over the next as reported on the Annual Return of Health Care Facilities Part I. Equivalent patient-days (EPD) are a weighted mix of inpatient days and outpatient visits.

Day/Visit	Value
Inpat. day (all types)	1
Day surgery visit	2
Day/night medical visit	2
Emergency visit	1/3
Other OPD visit	1/3

On the premise that cost increases would not have a fully variable relationship to workload increase the formula not a straight line allocation. The formula uses 50% of the equivalent patient-day growth with the adjustment to any individual hospital being up to a maximum limit of 2% of the Ministry of Health's funding allocation to that hospital.

In 1986/87, the formula was changed — based on recommendations by OHA and OCATH to include adjustments for average length of stay, physiotherapy and occupational therapy. Again, in 1987/88, a further adjustment was made to the system to allow for an advance payment to hospitals that had submitted their statistical data early. The remaining funds for growth for all hospitals that qualified are paid out when all submissions have been made and audited.

Note that both the growth-funding formula and the life-support funding formula are methods of allocating predetermined amounts of money to hospitals. They are not — and were never intended to be — a method of reimbursing full incremental costs of general workload growth or life support program growth.

6. Business-Oriented New Development Plan (BOND)

The Business-Oriented New Development Plan (BOND) was introduced on April1,1982. It is essentially a concept whereby hospitals are regarded as business organizations that should be operated in a businesslike manner, using business management techniques. To give tangible manifestations to the BOND concept, the Ministry took the following types of actions.

- The Ministry decontrolled rates to be charged by hospitals to patients for semi-private and private accommodation, thus allowing rates to be set by individual hospitals according to type of accommodation available and local market conditions;
- The Ministry decontrolled the rates to be charged to other third-party paying agencies such as the Workers' Compensation Board and the federal departments of Indian and Northern Affairs and Veterans Affairs;
- The Ministry encouraged hospitals to carefully re-examine the costs of delivering services to non-insured residents of Canada and non-residents of Canada — and to set rates that would recover at least the fully-allocated costs of the services;
- The Ministry encouraged hospitals to re-examine pricing structures for the sale of other goods and services, such as cafeteria

meals, parking, laundry, etc., to ensure that the fully-allocated costs of each service were being recovered;
- The Ministry decided to allow hospitals to retain 100% of any operating surplus earned in each fiscal year.

7. 1982/83: a critical year in the history of hospital financing

It is important, at this point, to recap the important events that took place at or around the beginning of fiscal 1982/83. This was a critical year in hospital financing.

As previously noted, the Ministry of Health introduced the BOND plan with its business-oriented approaches to revenue maximization, cost control and surplus retention. At this time, growth-funding adjustments were introduced for general workload and special life-support programs. These measures were intended to be improved ways for the government to respond financially to the growth in hospital caseload.

Also, at this time, the Ministry made a very significant and far-reaching funding decision: for each hospital that had ended fiscal 1981/82 with an operating deficit, the Ministry incorporated into the 1982/83 allocation to that hospital an amount equal to its prior year's deficit.

Following this decision, the Ministry altered the basis upon which a hospital's annual operating surplus or deficit had previously been calculated. Up to and including fiscal 1981/82, a hospital's operating surplus or deficit for Ministry of Health reporting purposes, had been calculated by excluding certain so-called "retained" hospital revenues and by excluding certain so-called "non-allowable" costs absorbed by the hospital. For the most part, these revenues were made up of the portions earned from semi-private and private accommodation, interest earned on invested funds, revenues earned from certain ancillary operations such as cafeteria, parking lots, and so forth. The costs excluded were primarily the matching expenditures to the foregoing revenue items. Invariably, hospitals had been earning an excess of "retained" revenue over "non-allowable" expenditures.

The effect of this alteration in the way in which a hospital's surplus or deficit was computed was essentially twofold:

- The surplus or deficit now represented the overall financial results of the hospital corporation as a whole and not some sub-set of that total position;
- Hospital officials argued that the "retained" surplus, which had previously been excluded from the operating surplus or deficit picture, would now be unavailable to them to finance equipment purchases, renovation projects and similar needed capital projects.

Notwithstanding the hospital's arguments concerning the unavailability of funds for capital projects, the infusion of approximately $118million into the system in fiscal 1982/83, as a result of the Ministry's recognition of prior year's deficits, produced a much-enhanced hospital financial picture.

On the negative side, however, two significant points do not seem to have been given much, if any, attention at the time. We believe they are important points to consider as we now move forward to examine improved funding policies and practices for Ontario's public hospital system:

a) No recognition seemed to have been given to the fact that the 1981/82 deficits reflected expenditure levels that when annualized, may have been significantly higher in 1982/83. Thus, everything else being equal, a hospital experiencing annualized expenditures would still have been under-funded in fiscal 1982/83;

b) There appears to have been no attempt to measure the relative performance levels of hospitals. The rolling over, therefore, of the 1981/82 deficits into the 1982/83 funding allocation likely perpetuated all existing inefficiencies.

8. Hospital funding components

The Ministry of Health has developed a multi-component mechanism for funding public hospitals in the province. These components are as follows:

a) Inflation/economic adjustment

Each year the Ministry increases the allocation to each public hospital by a common basic percentage, as an economic adjustment deemed to fund cost increases due to inflation in wages, benefits and in the prices of goods and services.

b) Small hospital adjustment

Public acute care hospitals of less than 50 beds, or with budgets less than about $3.5million, receive an additional 1% as part of their annual economic adjustment. This additional allocation is made to small hospitals to recognize their smaller economies of scale and the likelihood that they have less flexibility than larger hospitals in continually seeking out opportunities to increase efficiency.

c) Workload growth

Based on a formula, an additional allocation may be made to a hospital that has had an increase in inpatient and/or outpatient caseload. This formula adjustment is a method of allocating the approximately $40million per annum that is provided to the Ministry of Health for purposes of contributing toward the incremental costs associated with patient caseload growth.

d) Growth adjustment for life-support programs

Each year since 1982/83, the Ministry has allocated a sum of money ($12-$17million per annum) to designated hospitals to contribute toward the incremental costs of caseload growth in the following life-support programs:

- end-stage renal dialysis;
- cardiovascular surgery;
- total parenteral nutrition;
- oncology/chemotherapy;
- intra-ocular lens implants;
- neonatal intensive care;
- cyclosporine (immuno-suppressant drug);
- automatic implanted cardio-defibrillators.

e) New and expanded programs

Additional funding is allocated to hospitals that have had approval to introduce a new program or to expand an existing program. The additional funding is based on an incremental operating cost budget for the new or expanded program. There is generally a program establishment period of two to three years, during which a settlement will be made at each year end to cover the actual approved costs of the new or expanded program. At the end of this period, the costs of the new or expanded program are deemed to have stabilized and the funding is incorporated into the hospital's global funding envelope.

9. Appeals, performance measurement and special funding adjustments

The regular components of the annual funding adjustments to public hospitals have been described earlier in this report.

a) The alleged under-funding of inflation and wages, benefits and prices of goods and services

In addition ad hoc funding of hospitals has been used to address a number of issues. This includes:

- The cost increases in salaries, benefits, goods and services has exceeded the inflationary adjustment;
- The cost associated with changing case mix and changing case management have not been recognized.

b) Under-funding and productivity

As has been pointed out earlier, the Ministry and the government, in their funding policies, appear to have expected that hospitals would seek efficiency improvement opportunities to offset annual spreads between the basic economic percentage increase in the hospital's funding allocation and the actual percentage and dollar increase in wages, benefits and prices.

This policy has had limited success. Through regular performance analysis, the Institutional Division of the Ministry of Health has sought to draw hospitals' attention to efficiency-improvement opportunities. These performance analyses have been almost entirely centred on the operating performance of hospital departments. Overall global program or product line performance measurement of hospitals is currently impractical because of the inadequacies of available management information systems to relate clinical data to financial data. MIS guidelines have been produced by the federal and provincial government/association project. When the guidelines are applied to the global funding dimension, they should help to correct this situation.

In the meantime, hospitals and the Ministry of Health are limited largely to measuring individual departmental performance using existing production and productivity measuring tools. Crude though some of these measuring tools are today, when they are applied on a consistent basis from one year to the next, trend lines can be determined. For example, numbers of radiology units of work per employee or hours of work per meal day in the dietary department, provide usable methods of determining labour productivity for both planning and control.

Departmental labour productivity indicators can be calculated and compared within a hospital's own experience over a multi-year period or, with similar data from other hospitals of comparable size, function and operation. These performance indicators are not standards; they are merely guidelines whereby apparent trends in productivity improvement or deterioration can be detected. Where there is an appearance of productivity deterioration over a period of years the calculation can be made as to what adjustment would occur in both paid hours and dollars if the productivity of the department involved could be brought back to the "best year" productivity level. Similarly, analyses are carried out on non-labour costs, but again on a very crude and macro level. These non-labour cost analyses are designed simply to show the degree to which spending on goods and services, as a percentage increase over the prior year, has been contained within or has exceeded the percentage increase in the basic economic funding adjustment. Little work has been done to attempt to distinguish the causes of cost increases in goods and services between volume changes and price changes.

c) Case-mix and related funding

With respect to the second broad issue, that is, dealing with appeals for additional funding to meet cost increases resulting from case mix and case management changes, even less organized analytical work has been done. And, therefore, fewer results have occurred. It is true that, universally, in Canada and in other western nations with similar health care systems,

little has been accomplished, to date, to relate clinical to financial data for funding-determination purposes.

B. PRIVATE HOSPITALS

The role of private hospitals in Ontario has changed considerably over the past 25-30 years. In 1959, Ontario had 55 private hospitals. Many were active treatment facilities, including such larger secondary care facilities as the Doctors' Hospital, a 300-bed acute care hospital in Toronto.

Closure and transfer to public hospital status has reduced the number of private hospitals to 16 at the present time. Of these, two are specialty surgical hospitals, the Shouldice Hospital in Thornhill, specializing in hernia surgery and, One Medical Place in Toronto, specializing in minor orthopaedic surgery. Two other private hospitals provide psychiatric services: the Institute of Psychotherapy in Kingston and the Homewood Hospital in Guelph. The remaining 12 private hospitals provide long-term chronic care: They are all small hospitals and, for the most part, are located in small rural communities.

Reimbursement of private hospitals can be described as modified global funding. The global funding allocation is approved at the beginning of each year for each of the private hospitals. This allocation is based on the previous year's allocation, plus a percentage increase to cover inflation in wages and prices. A settlement is made at the year end to recover any total under-spending of the Ministry's allocation. Typically, any over-spending is absorbed by the hospital.

This modified global funding, with year-end settlement, has been in place since global funding was introduced for public hospitals in 1969. Prior to that time, private hospitals were reimbursed for approved line items of expense following a line-by-line review of budgets at the beginning of the year and audited financial statements at the end of the year. Approved costs included all acceptable patient care service expenditures, support service expenditures and depreciation on buildings and equipment — and also a provision for return on owner's equity. This return on investment was limited to 6-1/2% of the owner's equity as reported annually on the audited balance sheet.

Caseload growth funding has not been a significant issue with private hospitals since they have been operating at a very stable occupancy level, usually at or close to 100% of available capacity.

Financial difficulties encountered by private hospitals have generally been the result of:

- Wage and price increases in excess of the annual funding allocation increase;
- Additional nursing hours required to handle individual patients with higher care requirements than normal;
- Renovations and extraordinary maintenance;
- Purchase of new and replacement equipment.

C. CHILDREN'S TREATMENT CENTRES

In the 1960's the Ontario government, through the Ontario Hospital Services Commission, assumed program and reimbursement responsibility for the services provided by children's treatment centres. The province currently has 17 of these centres, located in various cities. They provide physiotherapy, occupational therapy and speech therapy services to children with muscloskeletal diseases and children with physical handicaps resulting from major trauma. The centres are scheduled under the Public Hospitals Act.

The funding of treatment service costs originally was performed on a cost-reimbursement basis, wherein the centre submitted an operating budget which was approved through a detailed

line-by-line review. Initial funding each year was based on the approved budget. A settlement was made to actual costs, again based on a line-by-line examination of the audited financial returns.

Because these centres have been treating children of school age and because the length of treatment is long — often of an indefinite duration —each centre has had an educational role as well as a health role. All direct costs associated with any educational services have been funded through local school boards. Direct health care costs, as approved in the budget and year-end review have been paid by the Ministry of Health. General support and administrative expenditures have been allocated between education and health services in the ratio of each of the component's direct costs to the sum of the direct costs of the centre.

In recent years, as with other types of facilities, the Ministry of Health has reimbursed child treatment centres on a modified global funding basis. In addition to the annual percentage increase for inflation, each centre was given the additional 1% "small hospital" adjustment. The centres were not, however, included in the growth-funding formula, because it would appear their occupancy levels were considered to be stable and usually at or close to maximum capacity.

Caseload growth has occurred, however, in certain centres in some years and the Ministry has responded to appeals with ad hoc growth-funding adjustments.

D. PSYCHIATRIC HOSPITALS

Ontario currently has 10 provincial psychiatric hospitals, down from the 14 that existed prior to 1976. The reduction in the number of hospitals was caused primarily by the introduction of psychotropic drugs and the increasing emphasis on the de-institutionalization of psychiatric patients. The psychiatric hospitals are operated as organizational units within the Ministry of Health through the Mental Health Operations Branch. Each hospital is managed by an on-site administrator who reports to the director of the branch.

The operating costs of each of the hospitals are part of the direct operating expenditures of the Ministry of Health. These direct operating expenditures are planned and controlled under an annual budget system prepared by the on-site management of each hospital and the management of the mental health operations branch for approval by senior Ministry management.
In addition to the direct operating expenditures of each hospital, the Ministry of Health provides, from its central office, financial, human resources, purchasing and other administrative services.

E. COMMUNITY PSYCHIATRIC SERVICES

The community mental health program was introduced by the Ministry of Health in 1976. It provides a range of services by a variety of health care professionals such as social workers, occupational therapists, nurses, psychologists and psychiatrists. Typically, the community mental health program includes: supportive housing programs, vocational and social rehabilitation programs, treatment programs and a network of community volunteer support programs.

These community mental health programs are delivered and managed by a variety of organizations including: public hospitals, Canadian Mental Health Association branches, public health units and other independent incorporated agencies. Reimbursement to these organizations is made through a cost-reimbursement system based upon approved operating budgets and actual year-end cost reports.

F. NURSING HOMES AND HOMES FOR THE AGED

1. Historical background

Until the early 1970's, nursing homes in Ontario were privately-owned, for-profit facilities providing residential care to people primarily 65 or older. In a minority of cases, a minimal amount of nursing care was provided, typically averaging around one hour of nursing care per day. Nursing homes charged a daily rate directly to each resident who would pay it out of their own personal income. Regulatory control was largely vested in municipalities, which licensed these nursing homes and inspected them through the Public Health Inspection Service.

Homes for the aged had for many years been organized either as municipally-owned homes or homes owned and operated by religious and other such charitable organizations. As their name implies, these homes were designed and intended as residential facilities for the elderly. Payment for services was derived from three basic sources:

- Payments by residents, both out of personal annual income and also from assignment of assets;
- Municipal financial assistance to Municipally-owned homes, at least to the extent of making up any annual shortfalls in revenues to meet total expenditures;
- A provincial grant mechanism through the Ministry of Community and Social Services, to help bridge any revenue shortfalls.

2. The Extended Health Care Plan

The Extended Health Care Plan (EHC) was introduced by the province on April 1, 1972. This plan was introduced as a response to the growing demand for long-term-care, both as a continuum of care following acute and chronic care phases and to provide nursing-level care for persons — particularly the elderly no longer able to cope with the functions of daily living in their own homes.

The Extended Health Care Plan became, essentially, an insured health service within the overall Ontario Health Insurance Plan. To be eligible for government payment benefits, an individual must be assessed by a physician and their physical condition rated on a point system. Those whose ratings qualify them as requiring a minimum of 1 1/2 hours of nursing care per day are given an extended health care benefit status. This entitles them to admission to a nursing home, or a home for the aged, under the EHC umbrella. And it entitles them to the benefits of government EHC payments on their behalf.

Originally, the government had decided to have the Extended Health Care Plan services delivered by the province's licensed nursing homes. Most nursing homes already had the basic physical and program structures in place, including nursing staff, to enable them to deliver extended health care services. Also, many nursing homes prior to April 1, 1972 had been operating at relatively low occupancy levels — in the order of 40%-60%. At that time there were approximately 20,000 beds in somewhat over 500 nursing homes in the province. Shortly after the plan's inception, these beds quickly became filled with persons who were qualified as extended health care beneficiaries. As the demand for extended health care services was still unmet, the government decided to use a portion of the capacity of homes for the aged — which also were physically and programmatically structured to enable them to deliver extended health care services.

In the beginning, the reimbursement system decided on was a straightforward rate per resident-day. Following negotiations with the nursing homes during the latter part of 1971, an initial rate per day was agreed upon. It was further agreed that the government would pay two-thirds of this rate, with the one-third balance being paid by the resident. The rationale for this allocation of payment responsibility was that the government would

pay the costs related to the delivery of actual health care services (i.e. nursing care, drugs, and medicines, physical activation programs, etc.) and the resident would pay for general living. Requiring each resident to pay for the cost of daily living seems to us to be conceptually valid in that the great majority of these residents stay there for the balance of their lives. It should be noted, however, that the split of the rate between the amount paid by government and the amount paid by the resident was arbitrary and — to our knowledge — was not based on any actual costing.

The extended health care rate has increased over the intervening years since 1972. Rate increases have occurred on an annual basis as a result of negotiations between the Ministry of Health and the Ontario Nursing Home Association. The same rate has been used to pay for extended health care services in homes for the aged, without any separate negotiation process. Payments are made monthly. The portion paid by the resident is called the co-payment rate.

The co-payment rate and the Government's portion is adjusted each quarter by an amount equal to the rise in the Old Age Security (OAS) and Guaranteed Annual Income Supplement (GAINS) payments. The co-payment is maintained at amounts that ensure that recipients of minimum OAS/GAINS payments are left with a "comfort allowance."

3. Adequacy of the extended health care rate and rate setting process

To determine the adequacy of the EHC rates and the process by which they have been established, we found it necessary to examine the key factors that have affected nursing homes, homes for the aged and changes that have taken place in the 16-1/2 years of the extended health care plan. In summary, these factors are as follows:

a) Mergers and consolidations

At the beginning of the extended health care plan in 1972 Ontario had over 500 nursing homes with approximately 20,000 beds. Today we have 330 nursing homes, containing approximately 30,000 beds. The reduction in the number of nursing homes is attributable almost entirely to the acquisition by larger nursing home operations of small, single-owner nursing homes. While the province still has a number of single-owner nursing homes, a major migration from single ownership to chain ownership took place in the first 10 years following the inception of the Extended Health Care Plan. This ownership change was accompanied in many instances by consolidation of the beds of two or more small homes into one larger nursing home. Often, too, this larger nursing home was one in a multi-home chain. Financially, this had the effect of producing increased efficiencies in both the direct provision of resident care and in administration. This factor helped nursing-home chains absorb wage and price inflation and other cost increases within the fixed standard per diem rate more easily than some individually-owned and operated nursing homes.

b) Old capital cost, low debt

Many of the nursing homes in existence on April1,1972 had been built or purchased at a time when land and construction costs were relatively low. They had been able to pay down or fully retire mortgage debt. As a result, from a cash-flow point of view there was little or no need for gross revenues to contribute to debt retirement. The owner then enjoyed the financial benefit to a greater extent than in a home where capital costs and mortgage debt were higher.

c) Renovation and restructuring

As the Extended Health Care Plan became more established and as the Ministry of Health applied more stringent physical plant standards, a number of nursing homes were required to spend money to upgrade their physical plants to maintain safety and also to keep the buildings in good functioning condition. For some nursing homes this may have reduced net income.

d) Labour costs

As an industry, the nursing home sector in Ontario is almost totally unionized. The majority of unionized employees belong to, and are represented by, either the Canadian Union of Public Employees (CUPE) or by the Service Employees International Union (SEIU). A significant pattern of central bargaining, involving many nursing homes, has developed a small number of "master agreements" covering a large number of employees. The bargaining strength by the unions has been held in check to some degree, it would appear, by equally forceful bargaining by nursing home owners. However, it should be noted that many agreements are now being settled through compulsory arbitration and a number of arbitrators have awarded wage and benefit increases without any recognition of the employer's "ability to pay." As a result, there are increasing pressures for greater increases in the per diem rate to avoid further shrinkage in net income.

e) Special program costing

In recent years, the Ministry of Health and the Ontario Nursing Home Association have agreed that a small number of program and administrative issues will be reimbursed outside the standard per diem rate. At the present time, these special reimbursement provisions are limited to payment of the direct cost of the Attends Contingency Program and a payment per resident-day to nursing homes that have been accredited by the Canadian Council on Health Facilities Accreditation. These are essentially cost-pass-through provisions. But they do mean that the standard per diem rate does not have to cover these additional cost items.

f) Funding anomalies

Under the Ontario scheme of things, nursing homes are operated under the Ontario Nursing Homes Act, which is administered by the Ontario Ministry of Health, and are reimbursed by the Ministry of Health. Homes for the aged operate under the Homes for the Aged Act, administered by the Ministry of Community and Social Services. The funding of nursing homes is very straightforward: a standard per diem rate paid in part by the Ministry of Health and in part by the resident, plus the special extra provisions noted above paid by the Ministry of Health. Also, nursing homes can charge residents a small differential rate for occupying semi-private and private accommodation. As well, they can charge nominal amounts for any personal services provided, such as mending clothes, or counselling on personal finances. Within these sources of funds, nursing homes must provide the required level of nursing care. They must purchase and administer all prescribed drugs and medicines. They must provide required special diets. And they must, of course, provide a safe, clean residential environment. Any surpluses earned by a nursing home are retained. Any losses must be absorbed by the owner.

Homes for the aged, on the other hand, have not only a greater variety of funding sources, but also have the ability to obtain funds to cover part or all of any annual operating deficit. In summary, the home

for the aged receives the extended health care rate for extended health care residents and in addition, is able to request an assignment of residents' assets. If it is a municipal home, it is eligible to receive municipal and provincial assistance in the event of revenue shortfalls. If it is a charitable home for the aged, the charitable association has recourse to the provincial government for partial assistance in the event of a deficit; the balance of any shortfall is funded through fund-raising proceeds.

The bottom-line in the funding difference between nursing homes and homes for the aged is, very simply, that a nursing home cannot exceed a certain cost per resident-day without getting into serious financial difficulty. A home for the aged on the other hand, may obtain relief from municipal government, provincial government and fund-raising sources.

G. PHYSICIANS

1. Historical background

It is useful to look at physician payment systems in Ontario from an historical perspective. The following points are presented chronologically:

- Prior to any formally structured physician payment systems, fees for service from well-off patients "subsidized" medical care for those patients who could pay little or nothing at all. It was understood that both groups of patients would receive equally good quality medical services. Patients who were neither rich nor poor, paid the physician a fee for each service as determined, apparently, by the individual physician;
- In the early decades of the 1900s, there were a variety of voluntary efforts to prepay part or all costs of unpredictable medical care. These early efforts included friendly societies, mining company and railroad employees' contracts, and the beginnings of commerical insurance. This was the beginning of third party insurance on a limited basis;
- Deprivations of the depression of the 1930s and of World War II pushed the issue of public health insurance onto the national political agenda, but the provinces could not agree on a national standard arrangement for transfer payments for publically funded health care including a physician payment system;
- Post World War II, commercial insurance companies and the creation and expansion of hospital and medical profession sponsored and controlled Blue Cross and Blue Shield prepayment plans really began the era of voluntary prepayment of unpredictable health care costs. Service-type contracts (first dollar and no exta-billing) introduced by Blue Cross and physician-sponsored programs were more expensive than commerical indemnity plans, but were nonetheless acceptable to Canadians (e.g. four million people had some protection against medical/surgical costs);
- By 1948, there were 100 private prepaid health insurance plans in Canada providing limited coverage on a reimbursement basis with two exceptions. In Ontario, exceptions were Associated Medical Services Inc. and Windsor Medical Services Inc. But, the public in Ontario was demanding a universal government insurance plan (including one for physician services). The Ontario Medical Association (OMA) had to respond to the inevitable;

- In 1947, the OMA recommended that a corporation to be called Physicians' Services Incorporated (PSI) be formed to offer a prepaid, comprehensive medical, surgical and obstetrical care plan. This was supported by the governing Council of the OMA. The PSI plan began to compete favourably with the private insurance plans. Doctors participating in PSI accepted 90% of the approved schedule of fees, recognizing that they had no collection costs or bad debts. The remaining 10% went to PSI for operational and capital costs, contingency costs, etc. PSI lasted until 1969;
- Universal physician services insurance in Ontario was introduced in October, 1968. Until that time, a medical welfare plan had made limited payments to doctors for selected categories of public assistance recipients since about 1935 and was administered by the OMA. In 1966 the plan was expanded and taken over by the Ontario Medical Services Insurance Plan (OMSIP). This plan operated as an alternative to private insurance plans from 1966 to 1969. It offered physicians a choice of billing procedure in individual cases (e.g. doctor would submit bill to OMSIP but be remunerated at 90% prorated payment and bill patient for additional amount **or**, physician would bill patient at 100% and patient would be reimbursed for 90% of the amount by OMSIP);
- The Ontario Government became the sole sponsor of health insurance plans in 1969 under the Ontario Health Services Insurance Plan (OHISP), but continued to offer physicians choice of billing procedure (as under OMSIP plan). It is not known the actual extent of extra billing that went on before 1971;
- By 1972, doctors were required to choose between either direct billing to patient at 100% or billing OHSIP for 90%.
- In 1972, the Ontario Health Insurance Plan (OHIP) was created to merge medical and hospital insurance. All billing records were consolidated;
- At the same time (1972), those physicians who chose to be opted out from OHIP could bill OHIP for services provided to war veterans or Indians or on a "good samaritan" basis. Approximately 13.5% of Ontario physicians had opted out of OHIP;
- In 1984, the Canada Health Act (federal legislation) legislated that provinces that permitted physicians to extra bill would lose federal transfer payments on a dollar-for-dollar basis. All provinces, including Ontario, moved to eliminate direct charges to patients between 1984-87. Ontario disallowed direct charges in 1986 under the Ontario Health Care Accessibility Act.

2. Funding physicians' services

Most Ontario physicians are paid on a fee-for-service basis under the Ontario Health Insurance Plan. The Government of Ontario negotiates with the Ontario Medical Association, usually once a year, increases to the schedule of benefits paid to general practitioners and specialists for each consultative, diagnostic and therapeutic service provided to patients.

3. Other payment systems for physicians

Other payment systems for physicians include:

a) The alternate payments programs

Alternative payment programs are provided through contractual arrangements with hospitals or physicians for the payment of physician services in lieu of billing OHIP. These services are provided primarily in hospital emergency departments, chronic and long-term care facilities and in a variety of other settings under the category of miscellaneous physician services. The development of an alternate payment system of funding was based mainly on the need for physician coverage

in emergency departments with high volumes and rapid turnover or isolated low-volume facilities with deficit problems.

b) Physicians employed in hospitals

Many hospitals, particularly larger ones, have full-time radiologists and pathologists on salary. Smaller hospitals retain the services of radiologists and pathologists on a part-time contract basis. In most cases the hospital finances these expenditures out of its global funding allocation and receive fee for service payments for some outpatient activity.

c) Clinical education

Funds are provided to hospitals by the Ministry of Health to pay for medical and dental clinical teachers and their secretaries, medical and dental interns and residents, allied health internships for physiotherapy, occupational therapy and speech therapy and audiology, dietetics, pharmacy, psychology, social work, bio-engineering and, for fellowships in cytogenetics, medical micro-biology and clinical chemistry. Also, under this program, the Ministry provides funds for instructors and registered nursing assistant, medical laboratory and radiotherapy personnel.

This funding is based on Ministry-approved number of positions at negotiated rates, instructor stipends and other factors.

d) Physicians employed by alternative health care organizations

Community Health Centres (CHC) and Health Service Organizations (HSO) are becoming established components of our health care system. Both models typically provide primary care services and are funded and structured so as to make maximum use of the skills of the multidisciplinary health care team and to foster health promotion and an orientation of wellness. The Community Health Centres have community boards and are most frequently funded through global budgets from the Ministry of Health. The Health Service Organizations are typically either physician or institution-sponsored and are funded through a system of capitation whereby capitation payments provide a fixed rate for an individual patient for a set period of time regardless of the extent to which the patient uses the services.

Physicians who are employed by a CHC are paid a salary for their services. In effect, the physician's salary is not related directly to the number of patients he/she sees (ie. as on a fee-for-service basis.) Rather, a straight salary (including benefits) is negotiated for a fixed term of service.

Physicians who are employed by an HSO are paid on a capitation basis (the number of enrolles in the program). When the HSOs acute hospital use is below that of the HSOs district, it receives an incentive payment based on the difference. The payment can be used by the HSO as it sees fit including, we understand, allocating part of the payment to the HSO physicians.

H. DRUG BENEFIT PLAN

The Ontario Drug Benefit plan (ODB) was established to provide free drug service to:

- Old Age Security (OAS) recipients;
- Recipients of home care benefits;
- Extended health care residents (nursing homes and homes for the aged);
- Homes for special-care residents;
- Recipients of social assistance through the Ministry of Community and Social Services.

Through negotiation with the Ontario Pharmacists Association, the Ontario Medical Association and the Pharmaceutical Manufacturers Association, the Government of Ontario has developed an Ontario drug benefit formulary. This formulary lists all of the drugs that can be prescribed for administration free of charge to the above-mentioned groups. The formulary is designed to incorporate both brand name and generic drugs. The intent of the formulary is for physicians to prescribe the most appropriate brand name or generic drug that will represent the lowest cost to the plan. This physician choice of interchangeability between brand and generic name drug is a major cornerstone of the Ontario drug benefit program.

The formulary sets out the prices that the government will pay under the plan. Through negotiation with the Ontario Pharmacists Association, a fee of $5.95 is currently paid to each pharmacist for each prescription dispensed. In addition, the pharmacist receives payment for the drug dispensed at the rate specified in the formulary. For over-the-counter drugs the formulary provides a method whereby payment can be made to cover the actual cost of the drug plus an allowance for the dispensing cost.

Annual increases in drug prices are made either in the form of a general inflation escalator or through negotiated increases in the price of specific drugs that may have had a more significant cost increase. Also, during the year, the government may respond to a request by a drug manufacturer for a price increase because of unanticipated cost increases of manufacturing the drug.

Persons eligible under the Ontario Drug Benefit plan receive an ODB card that they present to the pharmacist, or which is presented on their behalf if they are residents of long-term-care facilities. The pharmacist will dispense the drug free of charge and recover through a claim to the plan. Eligible persons unable to present the ODB plan card will pay the pharmacist and recover directly from the plan.

Similar to the Ontario Medical Care plan, the Ontario Drug Benefit is open-ended. That is, while the prices are pre-determined the volume of prescriptions is not controlled. As a result, the government's payments have increased significantly. For instance, in the three years 1984/1985 to 1987/88 payments increased from $348.3 million to $537.3 million, an average increase of 18% per year.

I. HOME CARE SERVICES

Ontario currently has 38 home care programs. Twenty-nine are operated through public health units and nine through other organizations such as the Ontario Red Cross and the Victorian Order of Nurses. In many cases the public health units sub-contract nursing and other services.

Each home care program submits an operating budget at the beginning of the year with an estimate of its caseload for the coming year. The budget is reviewed against caseload staffing and supply guidelines, on a line-by-line basis. The annual flow of funds is based on the approved budget. Actual cost and statistical reports are submitted at year end, reviewed on a line-by-line basis, and a final settlement made.

J. PUBLIC HEALTH

Forty-three local boards of health provide public health service to their communities. These services include maternal and family planning, pre-natal classes, school health, coordination of service to the elderly, community sanitation (including the inspection of food premises), community nutrition, preventive dental services

to school children, immunization, communicable disease control, and public health education. These programs are mandated by legislation and are available throughout the province. In addition, many health units provide home care services, adult protective social worker programs, infant stimulation programs, and private sewage disposal programs.

Each of the 43 local health units submits an operating budget to the Ministry. The budget displays, by line item of expense, the costs of providing its programs and services. The Ministry reviews the budget and funding is based upon the approved budget. Generally, increases in the allocation of funds to health units are limited to a general annual economic inflater. Health units may request additional funds for staff increases to cover workload increases or other program expansion, through the submission of a supplementary budget. This supplementary budget is also reviewed on a line-by-line basis to determine the reasonableness of planned staff increases against workload change.

We understand that plans currently are being developed within the Ministry of Health to amend the budget review and reimbursement of health units. Under this amended approach, health unit reimbursement would be program-related instead of being related to category of expense. The programs funded in this manner, we believe, include the core programs, noted above, which are mandated by legislation.

CHAPTER V
ISSUES AND PROBLEMS

Conflicting trends in the demand for health services and the supply of funds to finance them, together point to several "issues and problems" in the Ontario system. Some of these turn on points of funding and control and the state of health planning in the province. Others arise from our historical (and costly) focus on institutional delivery of health services. Technology has been fruitful but is spiralling upward in cost. Since health services are delivered primarily by people, whether in institutional jobs or not, manpower issues have a powerful effect on delivery costs. Socio-demographic factors have affected past demands and costs, and will be more, not less, important in future years. And finally, people in the province just want to be looked after. The typical Ontario consumer of health services is not concerned about their cost — either per unit of service, per prescription, or the overall cost of the system.

Overall, the cost of health care in Ontario is hovering on the brink of an unimpeded exponential increase into the 21st century. The issues this poses are no longer avoidable, and could lead to hard decisions by government.

Still, the people of Ontario expect the best. The issue is going to be **how** to deliver the best and how to pay for it.

During the course of our work we consulted with a number of individuals and groups to gain further insight into the operating of our present system. We wanted to develop an understanding of the future direction of the system, and the issues and problems related to the present operation. Finally we wanted to identify the opportunities for changes in the funding system. The following chapter summarizes the issues and problems raised during our consultations.

A. FUNDING AND CONTROL

1. Costs rising faster than Gross Provincial Product
The major problem within the health care system is that the rate of increase of health care costs has exceeded the growth rate of the Ontario economy. If this continues, future health care will consume a growing portion of resources in the provincial budget. This will be at the expense of other government programs.

2. Lack of incentives for controlling costs
In most health sectors there is no direct reward system for improved effectiveness or efficiency in health care delivery. The income of the majority of health care professions is not influenced by cost control or clinical success.

3. No bottom-up responsibility for controlling costs
The pressure for cost control does not reach the grass roots level of the health care system where costs are incurred, nor do consumers operate under any real constraints. Within the hospital system, there is an implicit motivational force driving up expenditures. Hospitals strive to add programs to meet their perception of community needs and compete with each other for additional resources. To a certain extent, hospital managers' salaries are determined by the size of their departments, therefore there is an inherent resistance to downsize facilities.

4. Imprecise funding procedures
The conjoint study of hospital operational reviews identified a lack of understanding and consistency in applying the hospital funding system over time. This creates difficulty in long-term financial operational planning. It also generates frustration among health care providers by attempting to operate within a fixed (arbitrarily determined) envelope of funds, yet having to respond to seemingly endless consumer demands.

5. Focus on controlling inputs, not outputs
The lack of clearly-defined outputs from the health care system makes it difficult to assess the relationship between outputs and expenditures. We are forced to measure the system

by throughputs such as patient days, procedures, laboratory tests etc. Few hospitals have a comprehensive utilization review process in place.

6. Health care research is under-funded
Ontario is significantly behind the U.S. in the percentage of the health care dollar allocated for health care research. This has wide ranging implications in terms of service delivery, education and the future development of our health care system. In particular, little research is being done on the cost effectiveness of health delivery.

7. OHIP is not a full insurance system
OHIP payments contribute only about one-sixth of total health expenditures yet the population believes it is "fully" insured and demands a "full service." Only 60% of the population pays OHIP premiums. The premiums themselves are not experience-related. Exemptions from OHIP premiums for the over 65 age group bears no relationship to the ability to pay.

B. PLANNING SYSTEMS

1. Duplication of services and lack of rationalization
Health care services, particularly in the hospital environment, exhibit much duplication in service. While we have seen some movement towards rationalization, much remains to be done. Communities strive for clinical self sufficiency demanding expensive equipment such as CT scanners and maintaining uneconomic sized units such as obstetrics. Hospitals are competitive and resist giving up programs often viewing this from a win/lose perspective of the individual hospital and the community it serves, not an overall gain to the system.

2. Lack of coordination
The district health council program has provided the forum to coordinate health care planning at the regional level. However, there is still much independent planning. Improved overall coordination could improve the impact of the health care dollar.

3. Trend toward expansion
Most planning appears to result in the development of a "bigger" system. New programs are initiated without the reduction of programs elsewhere. The system tends to be more "add-on" than "replacement" in focus.

4. Inequity of service delivery
The geographic distribution of our population appears to result in an inequity in service availability. This is both north vs south and urban vs rural.

5. Lack of perception of limited resources
Throughout the system everyone wants to spend more money to begin new programs. This is not normally done on the basis of saving money in other directions, but through requesting additional resources. There appears to no understanding that a dollar more on healthcare is a dollar less on education, transportation, child care, etc..

C. INSTITUTIONALLY-BASED SYSTEM

1. Institutional focus
The majority of the funding within the health care system is provided for institutions. Our rate of institutionalization is among the highest in the world. This is particularly relevant considering the still relatively young age profile of our current population.

2. Potential for community care not fully realized
We have made major strides in the development of non-institutional care to provide more service in the community. However, this is still a small percentage of the overall expenditure of the health care system. Also the relationship between replacement cost and add-on cost to community-based services has not yet been clearly established.

3. Physical plant requirements are looming
The capital redevelopment requirements of existing hospitals far exceed the provincial ability to pay. If we are to continue the present system, significant additional capital dollars will be required.

4. Focus on treatment, not prevention
The money spent on our health care system is mainly directed towards curative medicine and not preventive. There are strong indications that lifestyle is a major determinant of health. Therefore, preventing ill-health will in the long term reduce the overall cost of the system.

D. TECHNOLOGY

1. High-technology focus
The rate of increase in the cost of available health care technology is greater than our economic growth. For example, newer imaging techniques are extremely expensive, even though they do provide improved diagnostic capability. In many cases their effectiveness in terms of outcomes is unknown. Decisions must be made on where these expensive resources will be made available.

2. Drug costs are ballooning
The cost of pharmaceuticals has increased rapidly. Drugs such as THC and chemotherapy medications are very expensive. The rate of increase in these costs exceeds the growth in the economy. Developments in patent legislation may increase drug costs. The use of lower cost generic drugs offers significant scope for reducing drug expenditures.

E. MANPOWER

1. Higher wage rates
Many health care providers are paid higher wage rates than the Canadian national average. Support staff within health care institutions are paid significantly more than comparable positions in the private sector. On the other hand, there is some concern that because wage rates in the United States are higher than Canada highly skilled manpower may be lost to the United States. Hospitals are particularly concerned about wage settlements made beyond global budget increases; and the impact of pay equity legislation has yet to be fully felt on hospital wage bills.

2. Manpower shortages
At present, a number of the para-medical areas are experiencing manpower shortages. This includes nurses, pharmacists, physiotherapists and respiratory therapists. Medical manpower is also in short supply in such specialties as psychiatry, oncology and anaesthesia. A long-term manpower plan is needed for health professionals. Skilled manpower tends to be concentrated in the urban settings. This means geographical inequities in service delivery.

3. Trend toward professionalization in nursing
The trend towards the use of more RN staff within the health care sector may be contributing to the shortage of registered nurses.

F. SOCIO-DEMOGRAPHY

1. Aging population
The Ontario population is aging. The number of individuals over 65 is expected to double within the next twenty years. The health care spending patterns of our present health care system will have significantly more demands from this population trend.

2. Breakdown of the extended family
The mobility of Canadian families and the increase in single parent families has health care implications. Many of our elderly are no longer supported within the family and must be provided support through the insitutionally based system.

3. Culturally diverse market

The Ontario population, particularly in urban centres is culturally diverse. This cultural diversity presents particular needs that the health system must reflect. The health care sytem must be in a position to react to this.

4. Litigation

Health care providers are concerned that the impact of litigation on their operating costs is not fully appreciated. It is believed that many physicians practise defensive medicine, requesting tests for legal rather than clinical reasons.

5. Currency values

Canada has a high dependency on imported drugs, supplies and equipment. Movements in exchange rates have an impact on costs beyond the control of providers.

G. CONSUMER EXPECTATIONS

Ontarians are becoming increasingly knowledgeable about the determinants of health and the importance of health care. This has many positive implications — for example anti-smoking, anti-drinking, checkups, and a generally more health-conscious community. It also means that the people of Ontario have rising expectations of their health-care system. The problem is to do this in a controlled way that does not waste the available resources of the community and put undue pressure on public and private finances.

H. SUMMARY

Reviewing this list of issues and problems it is obvious that changes to the funding system cannot solve all our problems. Some problems can be solved by funding changes. Others can be supported or assisted by funding and incentive changes. Finally a group of issues will require overall system changes that are outside the scope of funding or incentive changes.

CHAPTER VI
A SURVEY OF EXPERIENCE IN OTHER COUNTRIES

A. FIVE COUNTRIES WITH VARIED EXPERIENCES

We briefly surveyed experiences in health-care organization and finance in five countries with varied funding and organizational arrangements — hoping that such an outside perspective would help the sub-committee in its assessment of options for Ontario. The five countries are: West Germany, Sweden, New Zealand, the United Kingdom, and the U.S.A.

One cannot, of course, capture the infinitely complex tapestry of national health administration in a few pages, nor express the subtleties of history and politics that lead a country to a given point in the evolution of its health care system. Here, we have set out a general overview of the group of five, through selected statistics; and have commented on certain aspects of their situations that may be at least tangentially relevant to Ontario. However, we caution against the importing of procedures and administrative techniques in the absence of socio-political circumstances that would favour their application in our province. Thus, we are looking for ideas and inspirations, not imports.

The five countries are very different in history and in approaches toward health-care administration and funding. Some of the features of their situations are expressed in Exhibit VI-1:

- The population of the United States is almost twice as large as the other four countries combined and is not heavily weighted in the 65+ group;
- Sweden and West Germany are richly endowed with inpatient beds per thousand of population compared with the UK and New Zealand, and more than twice the American ratio;
- The beds seem to get used, too. Average length of stay in Sweden and West Germany — where state-related funding is heavy — is more than twice as long as in the U.S., where state-related funding (Medicare and Medicaid) is just gathering momentum;
- Sweden and West Germany also have proportionately more practising physicians per thousand of population — twice the UK rate and substantially higher than even the U.S., where we tend to think of doctors being extra-plentiful;
- A seeming paradox also appears under the heading of "finance." U.S. total expenditures of $1388 per capita on health care are about the same as in Sweden — notwithstanding major differences in funding arrangements. In contrast, the costs in the UK and New Zealand are far lower.

EXHIBIT VI-1

Health care data for Sweden, West Germany, the United Kingdom, New Zealand and the U.S.A.

	Sweden	West Germany	UK	New Zealand	USA
Population (1983 — million)	8.3	61.4	56.4	3.2	234.5
Age profile (1983)					
% 65 or over	16.2	15.0	14.9	9.3	11.31
% 75 or over	6.2	5.5	5.6	3.2	4.4
% 80 or over	2.9	2.4	2.6	1.4	2.3
Projections to 2010					
% population 65 or over	17.5	20.4	14.6	12.0	12.8
Providers					
Inpatient beds per 1000 population (1983)	14.0	11.1[1]	8.1[2]	9.9	5.9[2]
Average length of stay (1981,days)	23.0	19.2	18.6	12.6	9.9
Hospital admission rate (admissions as % population 1981)	18.6	18.1	12.7	14.3	17.0
Practising physicians per 10,000 population (1983, '000)	24.1	23.7[1]	12.9[2]	16.9	19.4
Nurses per 10,000 population (1981, '000)	79.9	34.5	84.2	72.4	55.9[3]
Finance					
Total expenditure on health care per head[4] (1982, US$)	1,239.0	883.0	508.0	440.0	1,388.0
% Gross Domestic Product	9.7	8.2	5.9	5.7	10.6
% Public portion of total expenditure on health care (1982)[4]	91.8	78.7	90.2	87.6	42.1
Annual % growth rate differential per head (1970-84) (health care minus DGP)[4]	2.1	3.0	2.2	na	2.7

Sources: OECD, (*Measuring Health Care 1960-1983*, (Paris: 1985)
OECD, *Financing and Delivering Health Care, A comparative Analysis of OECD Countries*, (Paris: 1987)

[1]1982
[2]1981
[3]1980
[4]Using OECD purchasing-power-parity exchange rates to convert to U.S. dollars.

- The "bottom line" of Exhibit VI-1 is the second-to-last row in the table: the percentage of total expenditures that is publicly-funded. It ranges from 42% in the U.S.A. to 91.8% in Sweden.

  To a greater or lesser extent, all five countries are concerned about the control of health care costs. They are looking at the changing age profiles of their populations and wondering how more older people will affect the funding of health services. Common concerns are:

- Efficient matching of patient needs to services provided, for example, avoiding the use of acute hospital beds for the chronically ill.;
- Controlling the tendency for prices of health-related goods and services to increase faster than other prices;
- Controlling diffusion and use of high-technology medicine;
- Controlling the intensity of services supplied to elderly patients.

These all sound rather familiar in the Canadian context. So does a common concern with substituting less costly nurses for more costly physicians — the so-called "physician-extender" concept.

B. FINANCE IS A CONCERN

The control of health care costs is of concern everywhere. Changes in policy are under active consideration in most countries. The greatest success in containing costs in relation to Gross Domestic Product (GDP) seems to have been in countries adopting firm budgeting systems. For example, by:

- Capping total spending in public sector health care;
- Regulating physicians' and nurses' salaries or compensation;
- Using prospective rather than retrospective methods of reimbursing providers under public and private insurance systems of funding.

Part of the differential between the rate of growth of expenditure on health care and that of GDP arises from the "relative price effect." This is normally positive.

EXHIBIT VI-2

Compound annual rates of inflation, 1960-84

	Real medical care	Medical care	GDP	Differential expenditure
West Germany	5.6	4.3	1.2	4.2
UK	8.3	8.7	-0.4	4.4
New Zealand	n.a.	n.a.	n.a.	n.a.
U.S.A.	6.2	5.1	1.1	5.3

Source: OECD, *Financing and Delivery Health Care, a Comparative Analysis of OECD Countries,* (Paris: 1987), Table 22

C. WEST GERMANY

1. Organization

Germany is a federal country with 11 Laender corresponding roughly to Canadian provinces. The system of health care finance operates primarily through 1300 sickness funds. Some serve a locality; these cover about half of the insured population. Some are operated by trade unions. Most are operated by employers.

The sick funds are responsible for ensuring the availability of comprehensive care for their members. The funds can also control the reimbursement of fee-for-service physicians by not paying them, or reducing payment in cases of "extravagant" (idiosyncractic) claims by physicians. They are private non-profit organizations subject to federal regulation and statute. Most have an effective local or employment-based monopoly. "Substitute sickness funds" may be joined by white-collar workers. These generally pay cash indemnities for patients using private care.

2. Finance

The general principle governing "premiums" is neither experience nor community rating, but what in Europe is called the "solidarity" principle: contributions depend on "insurable earnings" up to a ceiling. In this respect, the German system somewhat resembles the decentralized Swedish and the centralized British systems. Patients can make supplementary payments, usually covered by private insurance, to purchase private rooms and other amenities in hospital.

Membership in a sickness fund is compulsory for the employed and self-employed up to an earnings ceiling. Premiums for the unemployed are paid by the social insurance system. Pensioners may also have their premiums paid, subject to a contribution record, or may pay on a scale according to income. There are specific patient charges for prescribed drugs, appliances, dental work, etc., with exemptions for some groups such as children and veterans.

3. Physicians

Primary care physicians are organized in regional associations. Until the 1960's these determined the number of physicians practising in the community. They still negotiate fee schedules with the sickness fund.

Physicians are thus private practitioners paid on a fee-for-service basis. There is a high degree of specialization among primary care physicians —far fewer GPs, for example, than in Britain. Any qualified physician is free to practice in any location of choice. Most family doctors are GPs, specialists in general medicine or paediatricians. But there is much referral from one to another in the primary care sector. Frequently a patient may regard more than one physician as their "family doctor."

4. Physicians in hospital practice

Patients in hospital are generally treated by a different set of physicians who are salaried employees of the hospital. Occasionally, privately-practising physicians in the community are also "attending physicians" in the hospitals. In private hospitals, doctors usually charge fees directly to patients. In the public and voluntary hospitals senior consultants (specialists) may do private work. Most of Germany's physicians are today hospital-based (75,000) rather than community-based (60,000.)

5. Hospitals

Hospitals are roughly equally private, public or voluntary. The larger hospitals are public. Reimbursement of hospitals from the sick funds is direct. Until 1986 it was based on a negotiated per diem. The practice has tended to encourage long inpatient stays, since the later days in a patient's stay are usually less

costly and earned the hospitals a surplus. "Prospective budgeting" is now the practice. Moves are afoot to switch to a DRG basis of prospective reimbursement.

6. Patient claim cheques are used to reimburse doctors

Patients are issued with claim cheques by their sick fund. The cheques are passed on to the physician treating them. The items of service supplied are listed by the physician and then passed each quarter to the regional medical association of which the physician is a member. The association acts as a post office, passing the claims on to the relevant sick fund. This sytem relieves the doctor from having to deal with a large number of insurance agencies.

7. Sickness fund income supplemented by governments

The income of the sickness funds is supplemented by payments by the Laender and the federal government, especially in regard to hospital costs and for special groups such as pensioners. This affords the authorities some influence in determining the quality and location of hospital care.

8. Private physicians have higher incomes

Within the German labour force medical incomes, especially in private sectors, are high. This, coupled with little control of location of practice and the entry to medical school, has given rise to the relatively large number of doctors per head in Germany. On the demand side this has been further fed by limits on the overtime permitted in hospitals —which must currently be specifically paid for and to which absolute limits are likely to be legislated shortly. Gross earnings for private physicians are about twice those of hospital doctors (and professors) and in some specialities (e.g., radiology), three times.

9. Public health

Public health agencies organized by the Laender and local authorities are responsible for registration of communicable diseases, hygiene in public places (restaurants, water supply, waste dumps, etc.), screening and much preventive medicine (vaccination, maternity and child care.) They are also responsible for providing for particular care groups, e.g., chronic sick, handicapped, addicts. They supervise all hospitals. Companies having more than 100 employees are required to sub-contract or provide their own occupational health centres.

10. Nurses

Nurses are mostly concentrated in hospitals and are fewer per capita than in most other developed countries.

11. Principal concerns: cost-containment.

Principal concerns in Germany have related to cost-containment. Since 1977 a National Conference has embraced all the major groups in German health care and finance. It meets twice a year and focuses mainly on the financing and medical effectiveness of the system. Although its decisions are not binding, it speaks with considerable authority. The recent reforms have included:

- The introduction of the computerization of the Sickness Fund system, with patients now having machine readable plastic insurance cards;
- Increases in (or introduction of) patient charges for ambulance services, dentures, spectacles and other prescriptions;
- Some out-of-pocket payments that may be partially reclaimed from the sickness funds;
- Supplementary dental charges for patients failing to attend the dentist regularly;
- Price controls on generic drugs with the difference in generic and branded in some cases being payable by the patient out-of-pocket;

- Reductions in death/burial benefits;
- Competition between hospitals is to be introduced with patients paying the difference between the least-cost local hospital and a costlier one of choice;
- There is to be an experiment with a "no claims bonus" in some sickness funds;
- Premiums for retirement pensioners are to be increased.

The rigid demarcation between primary and secondary care in Germany is likely to continue, given the tremendous economic interest of the primary care doctors.

D. SWEDEN

1. Organization

Health care in Sweden is primarily the responsibility of the 26 regional county councils, which include the three large municipalities of Malmo, Gothenburg and Gotland. The regional councils are responsible for inpatient acute care, primary care (including general dentistry for people up to age 19); and mental handicap, acute mental illness, and ambulance service.

Public health is the responsibility of 285 lower-tier municipalities, some of which, such as Stockholm, are very large.

Private practice is small in scale (about 5% of physicians); however 50% of dentists are private practitioners treating the adult population. About 5% of physicians are engaged in occupational health within industries. Sweden has a long history of decentralization. The pattern used for health care parallels other aspects of the welfare state. The National Board of Health and Welfare supervises and regulates medical care and seeks to ensure equality of access for the whole country.

Within this decentralized system, districts are responsible for the organization of primary care. Each has general practitioners, some specialists, at least one health centre and at least one nursing home for long-term care. Each provides district nurses, midwives and child health and maternity services.

School health services are operated by the municipalities (the education authorities.) Hospital services are provided by the county councils; some specialists centres are operated by groups of county councils affiliated with a regional tier of provision (for example, teaching hospitals, cardiology, neurosurgery, plastic surgery.)

2. Finance: user charges

Most health care is subject to modest user charges and is funded mainly out of:

- A national health insurance scheme financed by the state and employer contributions (15%, 85% respectively);
- County income taxes;
- Central government grants.

Users pay a consultation charge of about $7US to the county, up to an annual limit beyond which further consultations are free.

Physicians are salaried employees of the county. The insurance funds finance the councils' health programs by a capitation system based on the population serviced. Private practitioners may charge a fee up to $10US and are further compensated by the county, giving it substantial influence over the small private sector.

Prescriptions are charged up to a maximum of $8US per prescription, the balance being met by the national health insurance funds.

Inpatient care is subject to a per diem patient charge of $6US. The patient fees charged up to the maximum are at the discretion of the councils, except for the inpatient per diem, which is mandatory but subject to a maximum of 365 days.

A sickness benefit system provides up to 90% of normal income lost through illness, injury or handicap up to a ceiling. County council income taxation is proportional and accounts for approximately 60% of the costs of medical care. Central government subsidies compensate those county councils with relatively low tax bases.

In 1984 the sources of finance were:

- 50% county income taxation;
- 15% central government grants;
- 9% from national health insurance;
- 4% from patient charges;
- The balance from central government grants for education, research, etc.

3. Entry of physicians

Sweden has six medical schools. Entry is regulated at undergraduate and postgraduate levels according to estimated manpower needs (by a health planning committee of the national ministry.) This committee also seeks to control the areas in which physicians may practice. Its "recommendations" are not, however, always followed by the counties: the system is currently under review.

Central government regulations restrict the council's freedom of action. For example, they are required to provide inpatient and outpatient services, and major capital investments require ministerial approval. However, there is discretion regarding, for example, the pattern of primary care. This gives rise to considerable variation between councils.

4. Some private practices

The main areas of private practice are:

- Dentistry (about 50% of all dental care);
- Nursing homes and long-term mental hospitals;
- Primary private practice (about 15% of all primary physician visits);
- A very small number of private hospitals;
- The occupational health centres (mainly preventive care);

Sweden has about 10 private insurance firms mainly covering care in private hospitals (the national insurance scheme does not cover these) and special needs (e.g., additional family expenditures due to children's diseases.) The public hospitals usually have long waiting lists for elective surgery despite the high number of beds per population; this affords a reason for some modest growth in the demand for private insurance for care in a private hospital.

Some private providers of care are under contract to the councils, e.g., nursing/convalescent homes, long-term mental hospitals.

5. Licensing of physicians

Licensing of physicians and nurses is by the National Board. The Board also regulates standard hours of work and terms of service in negotiation with the professional associations. The Board registers approved drugs and —mainly via advice — the quality of care. It also attempts to coordinate the planning of the councils, offering advice, etc. Sweden, however, has made little attempt at cost-control with the exception of pharmaceuticals — where limits have been placed on the number of items per prescription.

6. Principal concerns: more competition and closer control of costs

Proposals for change include:

- Greater centralization (abolition of the county councils' responsibilities) via a national health provision scheme;
- Placing limits on councils' power to tax;
- Creating greater budgetary control over hospitals whose deficits were typically funded by the councils — and provided a case for a larger budget in the next accounting period;
- HMOs;
- DRGs;
- More use of private for-profit providers subject to the current financing arrangements;

- "Public competition" with capitation payments in primary care to encourage physicians to attract patients, and supplementary financial payments to those hospitals that attracted most clients.

E. THE UNITED KINGDOM

1. Organization

Hospitals, acute and long-stay, are mostly publicly owned. Hospital physicians are salaried. Community services such as ambulance service, chiropody, and physiotherapy are provided partly by District Health Authorities (which also manage hospitals) and partly by local government, e.g., district nurses, health visitors. Community general practitioners are independent contractors organized by public bodies (Family Practitioner Committees) paid by capitation, fee-for-service, and practice allowances and grants. GPs are funded on an open-ended basis. Patients pay no fees except for GP-prescribed drugs and some appliances (all subsidized.) Fees for service are paid to non-hospital-based dentists and opticians.

2. Finance

Hospital services are funded centrally out of general taxation and a part of national insurance funds (about 10%) to Regional Health Authorities (technically also the employers of hospital doctors.) This is done according to an equity-based formula. Funds are distributed to Regional Health Authorities (RHAs) and District Health Authorities (DHAs) according to "sub-regional" Regional Allocation Working Party (RAWPs) principles or other local principles. Capital and current ("revenue") costs are allocated separately with very little local virement possible. Private practice is possible for hospital specialists, (not junior doctors) in either National Health Service (NHS) hospitals or private hospitals. There is very limited private general practice. GPs refer patients to hospitals of their choice — the so-called "gate-keeper" role of the GP. Choice of the GP is up to the patient and the GP. An average GP has about 2,100 patients registered with him/her. Private insurance currently covers under 10% of the population, predominantly for elective surgery.

3. Entry of physicians

Entry to the medical profession is controlled by medical schools and the central government. Professional accreditations are via Royal Colleges. Disciplinary matters are handled by the General Medical Committee.

4. Comprehensive care

Services provided are in principle comprehensive — received either in an institution or in the community. Hospital waiting lists are formally compiled, mostly elective surgery, and drawn from at the discretion of individual hospital consultants. Waiting times are extremely variable.

5. Private hospital sector

Private hospitals, some for-profit, some non-profit — have about 10,000 beds, mostly acute, out of UK total of about 450 thousand including NHS pay beds. The main private insurance agency is the non-profit British United Provident Association (BUPA). Private hospitals and private physicians are reimbursed separately by the insurer.

F. NEW ZEALAND

1. Organization

Hospitals, acute and long-stay, may be public or privately owned, or they may be private but under contract to the public health care system. Physicians in hospitals are salaried. General practitioners are wholly independent and are paid on a fee-for-service basis (likewise dentistry and opticians.) This is a major respect in which New Zealand differs from the UK. In many respects the New Zealand health service is similar to the UK's. Historically,

New Zealand can claim the first "National Health Service." It is therefore easiest to identify those aspects in which it markedly differs from the UK.

A second major difference is its characteristic triumvirate management structure in which hospitals are run by a consensus top-management group of physician, nurse and an administrator. Such a system was in use in the UK but has been abandoned. This troika arrangement applies at most management levels in New Zealand hospitals.

2. Finance

Private health care insurance is subsidized via income tax-deductibility. Another major difference with the UK lies in a peculiarly New Zealand arrangement: the Accident Compensation Corporation. The ACC is a major funder of health care in New Zealand. Premiums for low-earners (or non-earners) are subsidised by the state. An accident victim is entitled to cost-reimbursement from the ACC that public hospitals are not permitted to receive. Such a victim is typically treated in a private hospital, which typically also pays higher salaries to its staff. This is a considerable advantage for the private system — which tends to specialize in such cases. Such cases are also favoured over others who will often have to wait for admission (even though their ill-health condition may be worse than that of an accident victim.)

3. Much like UK

Many of the other characteristics of New Zealand's system (and its problems) are images of those in the UK — even hospital waiting lists. Average waits for elective surgery in New Zealand exceed those in the UK.

G. THE USA

The chief feature of the American health care system is its tremendous diversity. Fundamentally it is a private system, with private insurance and private provisions. Some insurers are for-profit other are non-profit. Major public funding by the state is a national program for veterans, a national program for the elderly (Medicare) and state programs for the poor (Medicaid.) From the perspective of the Premier's Council on Health Strategy, the U.S. may be best seen as a gigantic social laboratory in which lots of different methods of finance and provision abound and can be compared over time and across states, institutions, etc. The U.S. is a world leader in work on quality assurance, outcome measurements, experiment in organizational forms (Health Maintenance Organizations, Preferred Provider Organizations, etc.), terms of access (user charges of various kinds for example) and methods of medical remuneration (fee-for-service, salary, etc.). Useful lessons are to be learned from the American experience, as from those of the other four countries reviewed — as noted below.

H. INITIATIVES FOR CONSIDERATION

Most of the five countries have done a lot more discussing than implementing when it comes to new arrangements. The richest source of information is undoubtedly the U.S.A. In what follows, some key issues are identified and the "state of play" in various countries reported as appropriate. The topics identified here are not exhaustive. They do provide a starting point that covers the principal initiatives being discussed most frequently.

1. Competition in health care provision

Greater competition is currently under intense public discussion in Britain. A Ministerial Review is expected to propose some move in this direction. Possibilities include:

a) Internal markets

Enthoven (an American health economist) proposed that District Health Authorities be given budgets with which to purchase services from other DHAs or provide them

directly themselves — a general extension of the "contracting out" that is on the increase. The proposal includes local wage and salary setting and allowing DHAs to borrow (up to a limit of prudence) at government long-term interest rates;

b) Provider-markets

Provider-markets are an extension of the internal market idea in which DHAs would provide no services at all, but contract with public and private institutions to provide for the population group for which each was responsible. GPs would be paid a two-part capitation, the first part (together with fee-for-service income and other allowances) would be designated, as now, to achieve a satisfactory target income for GPs; the second would be a set and adjusted allowance from which GPs would purchase drugs, outpatient and diagnostic services. etc.

Under both these proposals, equity considerations would still determine the DHA budgets. The general aim is to create market incentives for efficient provision, optimal balance between work done in the community and work done in hospitals. In a variant of the second plan, the DHAs would also receive income from a local health premium and would be elected bodies;

c) Health maintenance organizations (HMOs)

HMOs in the U.S.A. offer a comprehensive package of care in exchange for prepayment of a premium, with no further user-charges. The patient is locked into the physicians and facilities owned by or contracted to the HMO. Physician members of HMOs are usually paid by salary plus a share of profits. The general experience seems to have been that HMOs produce fewer and shorter hospital admissions, and no higher physician utilization. This is alleged to be more appropriate care. There is a suspicion that HMOs skim the better risks and that this may account for their apparent cost-effectiveness as well as the better health of HMO enrolees compared with the general population;

d) Preferred provider organizations. (PPOs)

PPOs are an arrangement by which insurers and employers enter into an agreement with selected (preferred) providers such as primary care physicians and hospitals to provide care at agreed costs per case and a fee schedule. Charges are lower than is usually the case. Premiums are paid by employers or shared with employees. The latter receive any necessary care with no further charges. Since providers have an incentive to retain contracts with the PPO, they have an incentive for efficiency. An advantage for the physician is that he/she is guaranteed a level of fee-for-service practice from the PPO during the period of the agreement. PPOs are still too young to have received thorough empirical assessments;

e) Health management units (HMUs)

Patients would, as now, register with GPs of their choice but the GPs would enroll with Health Management Units, replacing DHA's and RHAs. HMUs would be quasi-Health Maintenance Organizations with overall responsibility for the health of enrolled patients. HMUs would be reimbursed on a capitation basis by central government and GPs paid on a fee-for-service basis. Hospitals (public or private) would compete for the custom of the HMUs;

f) Managed health care organizations (MHCOs)

MHCOs would be tax-financed and combine the purchasing functions of Family Practitioner Committees and DHAs. RAWP principles would determine the budgets of MCHOs. Hospitals (public and private) would compete for the custom of MHCOs.

Patients could "top-up" receipt of services by out-of-pocket payments. Patients would join MHCOs rather than register with a specific GP as with HMUs;

g) Opting out of the NHS

Opting out of the National Health Service embraces internal or provider markets but, in addition, would permit some exemption from the "tax share" of opted-out individuals. Such people would purchase services in the private sector, either out of pocket or from extended private insurance;

h) Vouchers

The voucher scheme would award a voucher to each individual (or family) in a social insurance scheme. The voucher would be used to purchase "satisfactory medical coverage" from an approved supplier. The voucher could be topped-up and spent in either the public or private sector, the outcome depending on market forces. A variant would give vouchers to those also "opted out" of the NHS, equivalent to their tax share in the NHS, for use to purchase insurance via "health purchase unions" that would have a brokerage responsibility. Opted-out patients could use NHS facilities as private patients, for a fee;

i) Provider markets New Zealand style

The Gibbs Task force in New Zealand proposes that Regional Health Authorities would be funded on a population-based formula by a National Health Commission. The RHAs would be purchasing agents only, making contracts with public and private suppliers. The basis of contracting between public purchasing authorities and suppliers of service would be DRGs (diagnosis-related groups).

2. Other developments

a) Diagnosis-related groups (DRGs)

DRGs are the basis for a prospective method of reimbursing hospitals in the U.S.A. in the publicly-funded national medicare program (for the elderly) and the state-based Medicaid program (for the poor.) Diseases are classified according to their similarity and expected pattern of resource use in hospitals, costed out, and reimbursement rates thus determined.

The American evience to date seems to show that prospective reimbursement systems are better able to contain costs (costs per day and costs per admission) than retrospective reimbursement systems — especially if the latter reimburse hospitals for whatever costs they choose to claim. There is a suspicion that cost-shifting can occur (for example, of more dependent patients from acute to long-term care modes) and that patients may be discharged with lower health status. These results are, however, uncertain. It also seems that the cost-reducing effects may be offset to some extent by the increased throughput. A clear danger with *partial* movement towards DRG methods is that they may encourage shifting of patients into less cost-controlled modes of care.

b) Clinical budgeting

In the UK, information on costs and clinical activity was provided to clinical teams (budget holders) in an experimental group of hospitals. The management made PACTS (Planning Agreements with Clinical Teams) that prospectively determined activity levels and pay-offs to improved efficiency for the teams. Evidence to date does not suggest any perceptible changes in use of drugs, X-ray film, X-ray chemicals and equipment, medical surgical supplies or laboratory instruments. The experiment is, however, ongoing.

c) Competitive insurance

Several issues need thorough exploration in connection with any move towards greater dependence on private insurance.

(I) Adverse selection

Premiums set at average community risks will seem high to low-risk groups who may therefore choose "self-insurance" (i.e. no insurance!.) Either they are then exposed financially (or health-wise) if the unexpected happens or (as seems more likely) competitive insurers (including HMOs and PPOs) are encouraged to experience-rate by offering lower premiums to low-risk clients. Community risk raters are left with the worst risk and hence raise premiums (further intensifying the problem.) If the community risk rater is a public agency a dual class of service may result with public hospitals taking the increasingly elderly, the medically indigent, and low social class groups. Since those facing the highest premiums in a market system will be those with the lowest incomes (health and income being inversely correlated) major issues of equity can arise. In the U.S.A. over 30 million people are estimated to be uninsured or inadequately insured.

(II) Moral hazard

Both private insurance and social insurance imply a low or zero user-charge at the point of use. This encourages demand, but generates upward pressure on premiums unless the "moral hazard" is controlled by the insurer (e.g., by specifying standards of care, limits on length of hospital stay.) The question arises whether these controls are better imposed by private insurers or by publicly-accountable agencies directly controlling public providers, or by private providers under contract to public-financing agencies. Moral hazard is also met by imposing deductibles and co-payments on patients.

(III) Loading of premiums

Insurance companies incur costs of drawing contracts, billing, dealing with claims, monitoring fraud, etc. These all raise premiums by a "loading" element that can be much smaller under social, compulsory, comprehensive insurance schemes.

d) Patient charges

There is widespread evidence that patient charges, co-payments and deductibles affect utilization. There is some Canadian evidence on the effects of such charges. Of the five countries in the review, the main source of evidence is again the U.S.A. Price-elasticities for all health care have been estimated in the 0.1 to 0.2 range (i.e., a 10% increase in charges causes utilization to fall by from 1% to 2%.) The effects were much stronger, however, for the poor, for children and especially for the children of the poor. This gives rise to the danger of progressive disadvantage. For example, the handicapping effects of untreated otitis media in children include progressive deafness, educational disadvantages, further social disadvantage and subsequent career blighting as these effects are compounded over time.

e) New management concepts

The UK has recently moved towards general management in the NHS and New Zealand is likely to follow. This entails managers being accountable for clearly-defined units of work and being monitored for success and failure. New training programs have been instituted. Senior general managers are on performance-related pay and have short-term contracts that need not be renewed if performance is inadequate.

CHAPTER VII
ANALYSIS OF ALTERNATIVES

A. INTRODUCTION

The process by which funds are transferred from government sources to service providers is referred to as a reimbursement mechanism. The purpose of this section of the report is to describe a series of alternative reimbursement mechanisms and to discuss some of the advantages and disadvantages of these alternatives. More specifically, the goal is:

- To outline a method for systematically classifying reimbursement alternatives;
- To suggest a general framework that can be used to evaluate the impacts of these alternatives.

A large number of different reimbursement mechanisms are either currently in use or have been discussed in the literature. While each of these mechanisms is distinct, all share two basic properties:

- A unit of output upon which reimbursement is based;
- A process by which the price per unit of output is determined.

These two properties can be used to provide a systematic classification of reimbursement alternatives.

1. "Bundling" of services

The unit of output is the measure that is used to define the quantity of output that is purchased. In health care, that output or product is generally measured in terms of services provided. Services can be measured at different levels of aggregation, from very specific and discrete individual services to larger sets or groups of services. The term "bundling" is often used to describe the level of aggregation. At one end of the spectrum of aggregation are the unbundled services found in fee for servce or itemized charge reimbursement alternatives. At the other end of the spectrum are capitation mechanisms that bundle together all the services that are received by an individual over a time period. Between these two are a series of alternatives that represent varying levels of aggregation. The level of aggregation or bundling can be used to define one dimension of a classification of reimbursement alternatives. For each level of aggregation the manner in which the price or reimbursement level is determined can be used to define another classification dimension.

One characteristic of pricing that is important in describing reimbursement alternatives is whether the price is set prospectively or retrospectively. In a prospective system the price is negotiated or determined before the service is provided. In a retrospective system the price is negotiated after the service is provided.

Another feature of pricing mechanisms is the process used to determine the price. The United States is the only developed country in which a process resembling a "free market" is used to determine the price. In all other jurisdictions there is either some form of explicit collective bargaining over prices, or prices are set by government with some form of implicit understanding between government and providers. Whatever the process, the purpose is to define a set of relative prices for the different types of outputs. This may involve setting prices for the large number of services that might be found in a fee-for-service alternative; or the limited number of categories of coverage that might be found in a capitation alternative.

The importance of describing reimbursement alternatives in terms of the unit of output and price setting mechanisms is that both of these properties are important to an understanding of the incentives generated by different funding alternatives. Although these incentives can be couched in elegant theoretical terms, the fundamental notion underlying reimbursement incentives is simply "you get what you pay for." In other words, the

characteristics of the reimbursement mechanism can be expected to affect the behaviour of service providers. At one level, the unit of output used to define the reimbursement alternative can act as a signal to providers of the type of services that they should provide and the production process they should employ. At another level, the prices set by the reimbursement system can act as signals to providers about the amount and the mix of services that should be provided.

The construction of a systematic classification of alternatives is the first step in developing rational and effective reimbursement policies. The second step involves evaluating the impact of these alternatives.

The evaluation of policy alternatives should be based on the ability of those alternatives to bring performance of the health care system in line with the policy objectives of the provincial government. Since the performance of the health care system is dictated by the behaviour of consumers, institutions and providers, government policy has to work through its effects on these stakeholders. Thus, evaluation of policy alternatives should involve both a clear statement of policy objectives and understanding of the effects of policies on the various players in the health care system.

At a general level, the goals of the provincial government fall into three broad categories:

- Equity of access;
- Costs of care;
- Quality of care.

Therefore, a basic framework for the assessment of reimbursement alternatives would examine their effects on each of these broad goals. Since policy alternatives may simultaneously have positive effects on some goals (e.g., quality of care) and negative effects on others (e.g., costs of care,) the ultimate choice between alternatives may involve a trade-off between goals. By carefully examining the effects of policy alternatives on each category of goals, systematic evaluation can make these trade-offs explicit.

While the provincial government has broad policy goals, it also has a set of more specific goals. It is beyond the scope of this report to identify all of these goals and to discuss reimbursement alternatives in terms of their effects on these goals. However, the recent Ontario Health Review Panel identified some goals that will be discussed in this report. These goals include:

- Increased emphasis on health promotion and disease prevention;
- Decreased emphasis on the institutional sector and development of an environment that would foster better coordination of the various types of health care services;
- Development of a more pluralistic system that allows consumers to make informed choices.

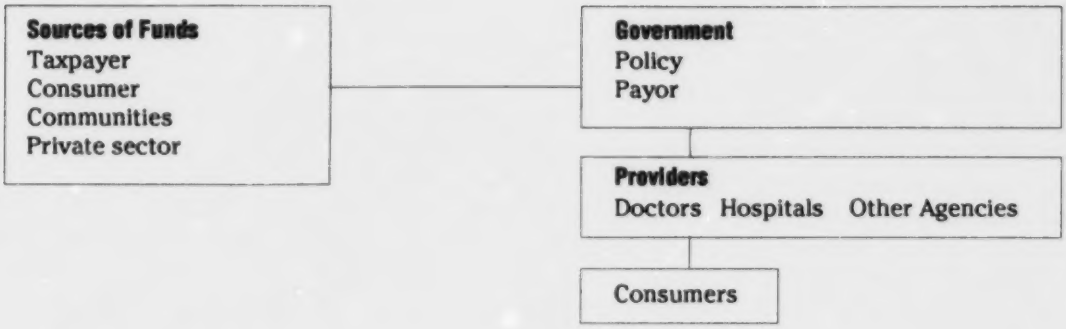
B. ORGANIZATION AND LINKAGES

1. Current arrangements

The mechanisms used to raise and disburse funds for health care must be assessed within a framework that considers organizational arrangements and linkages between the key components of the system.

Exhibit VII-1 illustrates the linkages between sources of revenue and their consumption by health care consumers. In some circumstances constituent elements of the system perform two roles: for example taxpayers may also be consumers. Similarly central government, through its direct management of psychiatric hospitals is both a provider and also fulfills the role of resource allocator through its policy decisions. A key feature of current organizational linkages is the enormous number of hospitals, agencies and other providers that have direct linkages with

EXHIBIT VII-1



the provincial government. The integration of the constituent elements of the health care system takes place at the provincial government level, an organizational level far removed from the delivery or consumption of services.

Approaches to management and service delivery are moving in two directions that are at variance with the current organizational arrangements in Ontario. Management of health systems are becoming increasingly decentralized. Central governments are providing the strategic direction for health systems and regional or local units of management are providing services within these strategic parameters. Service delivery models are increasingly emphasizing both horizontal and vertical integration of services focussed on specific client groups in one-stop access programs. We previously commented upon the need for rationalization and integration of providers. There is also a need at the provincial government level to integrate the components that make up the health system. Health, and health care in its broadest sense, crosses ministerial boundaries. Housing, education and social services all have a significant impact on health delivery systems and clearly, policy initiatives in one component of a health system must be made with due regard to other key components of the system.

From a provider's perspective, direct access to central government provides a platform to use political leverage to influence individual funding issues. However, the current centralized control over resource allocation decisions provides limited local influence over how money should be spent within the community.

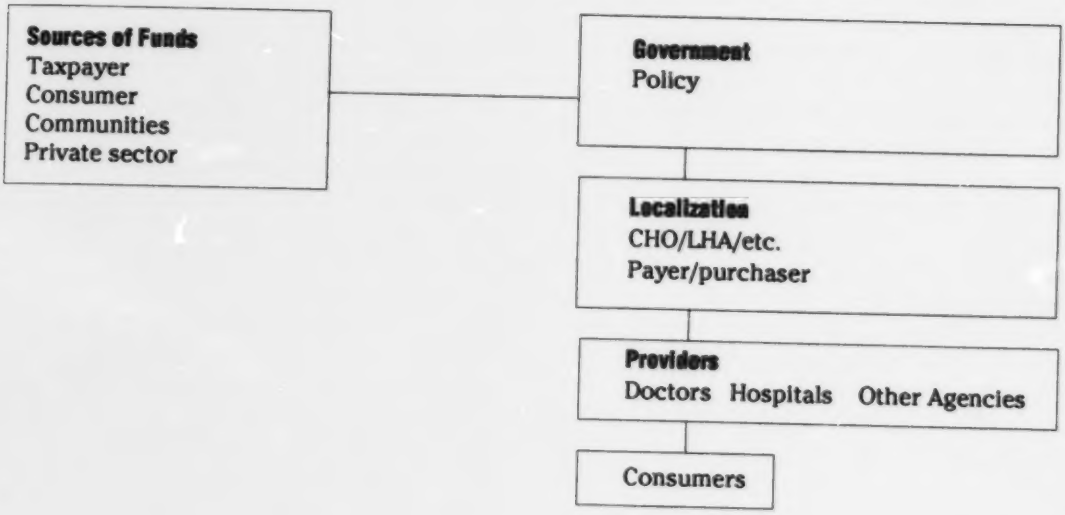
From a consumer's perspective, the greatest irritant in current arrangements is the lack of integration of services. Patients are frequently faced with a bureaucratic maze when trying to secure a full range of services.

Overall there appear to be strong arguments in favour of more decentralized management, combined with larger units of management that facilitate service integration and avoid duplication.

2. Options and alternatives

The move to a more decentralized form of management in essence requires delegating some of the functions currently undertaken by central government to community groups or institutions. This would not require the introduction of another bureaucratic tier between government and providers, but it would require a transfer of responsibilities. This is illustrated schematically in exhibit VII-2.

EXHIBIT VII-2



A number of options are available for policy makers:

a) Localization

The National Health Service in the UK has operated under a regionalized structure for 40 years. New Zealand is currently moving to a regionalized system and a number of European countries also organize their health services on a regional basis.

A localized structure could take a number of forms. As an example, it could have the following features:

- An independent Local Health Agency led by a chairman appointed by and directly accountable to the Minister of Health. The LHA membership could include representatives such as Board Chairmen of local hospitals, other agencies, a nurse representative, physicians (specialist, general practitioner and community health) and community representatives. LHA members including the chairman would be part-time but should be paid a significant stipend for their duties. Under this organizational arrangement District Health Councils could be eliminated;
- A Local Health Agency Executive could be established to provide administrative support for the LHA. The LHA could be led by an Executive Director who would also be a member of the health authority with full voting rights. Remuneration for the Executive Director should be set at a level to attract the best health executives within the industry. Remuneration should also include a significant performance related component;
- The key responsibility of the LHA could include:
  - Setting the regional strategic plan for institutional, community or preventative health services;
  - Acting as purchasing agent for health services within the region;
  - Establishing and implementing regional utilization reviews;
  - Establishing the regional manpower plan including the medical manpower plan;
  - Monitoring the operational efficiency of all health care providers;
  - Approving and funding all new and expanded programs within the region;
  - Acting as "paymaster" on behalf of the Minister for all approved programs;
  - Planning and approving all capital developments.

Localized funding could adopt something like the British "RAWP" sytem to promote equity within the systems. The key components of this funding system are:

- Basic capitation payment;
- A weighting for population structure (e.g., for the elderly);
- A morbidity weighting;
- A cost weighting (e.g., to reflect costs of service provision in various geographic locations);
- An economic adjustment to reflect cross-boundary flows.

The funding formula could also be adjusted to reflect teaching and research responsibilities.

This arrangement offers a number of benefits:

- The structure would allow the Ministry to focus on strategic issues and reduce involvement in operational matters;
- LHA would control the allocation of resources to meet locally determined priorities. Rationalization and efficiency benefits would be retained by the LHA;
- Service providers would participate in the resource allocation process. A regional authority to fund programs would speed up the funding of new and expanded programs.

b) Comprehensive Health Organizations (CHO)

A further level of delegated control over services could take the form of a Comprehensive Health Organization. CHOs could be a much smaller management unit than say a Local Health Authority, however they would have many similar features. For example, a CHO could be funded by capitation; it would promote both vertical and horizontal integration and built-in incentives for low-cost, non-institutional care.

This model of health delivery is already under review by the Ministry of Health and a number of feasibility studies are being undertaken. The key characteristics of CHOs outlined by the Ministry of Health are as follows:

- Relationship with HSOs and CHCs: Selected larger HSOs may wish to consider CHO sponsorship. Many networks of CHCs and/or HSOs may be in the initial stage of phased developments leading to CHOs;
- Sponsorship: CHOs would be sponsored by a management structure directed by a non-profit community board. This would not preclude the involvement of for-profit groups provided overall responsibility for the CHO resides with a non-profit board;
- Members: CHOs would serve a population representative of the community at large, who would voluntarily enroll. No individual would be refused membership or expelled on the basis of their health status;
- Funding: Developmental CHOs would access time-limited pre-operational funding from the Health Innovation Fund. Operational funding would consist of capitation funding and program budgets. Capital would not be available until after demonstration programs were evaluated.

CHOs offer significant advantages in terms of transitional arrangements. Hospitals and large HSOs already have in place much of the management infrastructure required to operate a CHO. Hospitals are, in many places, the focal point for a community's health needs. The extension of their responsibilities to include non-institutional care could be an evolutionary development.

c) Expansion of the role of District Health Councils

Since their inception, debate has ranged periodically about the advantages (or otherwise) of giving DHC's executive authority, or management responsibilities for the system. Their role, to date, has been as advisers to the Ministry on local issues – particularly planning issues. This is their focus, and their strength. To graft on to this an entirely new set of responsibilities would so change the nature of the DHC's membership and staff, as to preserve only the name – "District Health Council" ; but in effect it would create a new organization that would not be intrinsically different from the "Local Health Agency" (LHA) model mentioned earlier.

d) Expansion of the roles and responsibilities of hospital boards

It would also be possible to consider expanding the roles and responsibilities of hospital boards, so as to encompass the management and planning of other services. Certainly, most hospital boards have fairly wide community representation. They also have a cadre of trained professional health care managers to assist them. Certainly there could be objections from community health groups if hospitals became the focal point for managing the delivery of all health care in an area. Interestingly, however, in a least two areas of Ontario hospital boards are currently trying to develop some organizational model that would integrate the management of all health services. Something similar to the CHO model may evolve.

C. ALTERNATIVE MECHANISMS FOR PHYSICIAN REIMBURSEMENT

1. The main funding mechanism is fee-for-service through OHIP

The dominant source of reimbursement for physicians in Ontario is the Ontario Health Insurance Plan. In recent years, the Ministry of Health (MOH) has been exposed to rapid increases in OHIP expenditures. Total expenditures for OHIP payments to physicians and other practitioners quadrupled in a ten-year period, from $900 million in 1977-78 to $3.6 billion in 1987-88. This represents an average increase of 15% per year, a rate of growth far higher than that of the provincial economy or of the provincial government revenue base. Physician payments are taking up an increasing share of the MOH budget. These cost concerns go beyond the amount of funds directly transferred to physicians, because the behaviour of physicians is a major determinant of hospital, laboratory and prescription drug costs. Physician reimbursement policies can have profound implications for overall health care costs.

Along with its concerns over costs, the government is also concerned with the geographic distribution of physicians. Even after a period of rapid increase in the overall physician-to-population ratio, many areas of the province still do not have enough physicians. This raises the issue of equitable access to services for people who live in those areas.

While the provincial government is clearly interested in the quality of medical care, responsibility for it has been delegated to the medical profession. One should not be surprised, therefore, to hear physicians' concerns over the impact of reimbursement policy on the quality of care.

The following discussion of physician reimbursement mechanisms attempts to identify the major alternatives and their impact on the costs of care, the quality of care and access to care. In response to the concern over the need to increase the delivery of disease prevention and health promotion services, the incentives for the production of these types of services are specifically addressed.

2. Reimbursement alternatives and their effects

a) Fee-for-service payment

A fee-for-service (FFS) reimbursement system defines as the unit of output a discrete and well-defined service or a set of related services. The services included in the system are identified in a schedule of benefits. A large number of benefits may be defined in a schedule. For example, the OHIP schedule contains over 9,000 separate services, with benefits varying in the degree of bundling of services. For example, a schedule may include benefits that group services into episodes of care, such as care during pregnancy and delivery; the same schedule may include very discrete services, such as a specific laboratory test.

In virtually all cases of FFS reimbursement, the prices for each of the benefits are determined in advance. A fee schedule is established and used for a period of time before the fees are renegotiated. The relative prices for the elements of the fee schedule are either determined by the payer unilaterally or by the payer in conjunction with the provider. In Ontario, the government negotiates with the physicians (through the OMA) on the overall price increases, with the OMA usually having a great deal of control over the relative prices of the individual items in the schedule.

i) Fee-for-service system provides many variations

Although the basic characteristic of FFS payment –reimbursement on a per-service basis – is fairly straightforward, many variations of the approach exist. A FFS system can be altered by changing the items that are included in the schedule or by bundling or de-bundling services. A FFS system can be altered by changing the process used to determine the relative prices of service.

A FFS system can be combined with expenditure caps, utilization caps, income caps, or some combination of all three. The presence of these "modifications" to basic FFS payment can have significant effects on the types and extent of the incentives produced.

Both the OMA and many individual physicians have indicated a preference for FFS payment over alternative payment mechanisms. FFS provides a direct link between the volume of work and the payment for that work, and as such rewards more industrious or productive physicians. To the extent that fees reflect the relative complexity and skill requirements of particular procedures, a FFS system compensates physicians in accordance with the difficulty of the services actually provided. Thus, it provides a means of establishing a differential financial reward structure for physicians with different case mixes and loads.

A FFS system also allows physicians a considerable degree of control over their own incomes. Although fees are controlled, at least over the contract period, billings and gross incomes are not. To some extent, therefore, individual physicians are able to determine their incomes by deciding on their workload.

This control may be in part responsible for the traditional view of the profession that FFS is associated with (some would go as far to say synonymous with) clinical freedom. The mix of services provided by an individual physician is decided by the physician alone and not dictated by governments or managers of group practices.

II) Physicians have some concerns with FFS

On the negative side, some physicians are concerned that, because of the rigidity of a fee schedule, certain important and efficacious procedures cannot be provided at all, or to the degree necessary. Preventive services and health promotion counselling are often cited as examples of uninsured or underinsured services that are infrequently provided because of the structure of the existing fee schedule. But the FFS system per se is not necessarily responsible for the under-provision of these services. Presumably, a fee schedule could be designed to allow, or through its pricing structure even to encourage, disease prevention and health promotion activities. The fact that this has not occurred to date may be more a reflection of the architects of the schedule than of the reimbursement mechanism itself.

III) FFS service tends to be open-ended -- some provinces have introduced control

The major problem with FFS, from a funding perspective, is that expenditures on physicians' services are difficult to control and predict. The open-ended nature of FFS can lead to escalating costs. The inflationary effects of the FFS system occur because there is often no control over the number of services billed. Or over the "de-bundling" of services, which allows more services to be billed for a given episode of care. As mentioned earlier, modifications to FFS could be used to constrain quantity increases.

To date, some provinces have instituted some sort of quantity, or utilization, controls in addition to the price controls inherent in a fixed fee schedule. These utilization controls work by adjusting total payments to physicians to reflect changes in the volume of services provided. In other words, if service volume increases beyond some specified level, subsequent payments will be adjusted downward. Quebec combines utilization controls with income controls; in the latter, income ceilings are set, beyond which physicians are reimbursed at 25% of list fees.

Although the capping initiatives have not been in place long enough to evaluate their impact, results from Quebec indicate that capping of incomes, in addition to utilization, has been fairly successful in constraining costs. It is premature to comment on the extent to which utilization caps alone can regulate medical expenditures; much depends on the resolve of the government in negotiating and enforcing caps, and the clout of medical associations in fighting them. What is known, however, is that in the absence of controls on utilization, FFS tends to promote cost escalation.

One advantage of FFS for a public insurer is that the system provides a record of the number and types of procedures provided by each physician and in total. It is thus possible to monitor changes in the mix of services, trends over time, and individual physician profiles. The latter are especially useful for audit purposes. Information on the numbers and types of services is typically not available from capitated or salaried practices, other than through chart review – a costly and time-consuming process.

In addition, because FFS reimburses on a procedure-specific basis, it is possible, at least in theory, to alter the mix of services provided by altering the relative fees for them. For example, if a

priority were to encourage immunizations, the fee could be increased in an effort to "signal" physicians and induce a change in practice. Of course the success of this strategy depends crucially on the extent to which physicians respond to relative price signals –something we know very little about in the Canadian context.

Often, the patient is not directly aware of how his/her physician is reimbursed. In a recent survey of patients in a Hamilton Health Service Organization (HSO), over two-thirds were unaware that the practice was paid on a capitation basis. Yet patients can be affected in a number of ways by the how their physician is paid.

iv) Financial incentives in FFS provide the potential for over- servicing, de-listing, and long line-ups

First, the financial incentives inherent in FFS provide the potential for overservicing. Patients may be seen more frequently than necessary or receive more intensive servicing per visit than is necessary. Interestingly, though, the evidence from U.S. studies of FFS versus capitation indicate that although hospitalization rates are higher for FFS patients, the number of ambulatory visits is not. However, the number of ancillary services (e.g. laboratory and radiology tests) per visit and per patient is higher in the FFS sector.

Second, because highly technological services have historically been more remunerative than, say, counselling, the FFS system has encouraged substitution of high tech (and costly) procedures for more labour-intensive alternatives. But, as mentioned earlier, there is nothing to preclude a restructuring of the fee schedule in an effort to provide incentives and signals to modify practice behaviour. In fact, recent initiatives in the U.S. to construct a "resource-based relative value scale" have been undertaken for the purpose of developing a fee schedule that accurately reimburses physicians for the skill requirements, complexity and costs of providing specific procedures.

The third way FFS may affect patient outcomes is through the constraints that a fee schedule imposes on the range of services available. As was the case recently in Alberta, services can be de-listed, leaving patients wholly responsible for payment for those services should they require them. Indeed the public outcry form the discontinuation of what many thought to be essential services was largely responsible for the re-establishment of the services as insured benefits.

Fourth, many physicians argue that the OHIP fee levels are so low that they are forced into a "turnstile" or "revolving door" style of medicine that is detrimental to patient well-being. Waiting times are increased and contact time with the physician is decreased. The extent to which this has actually happened as a result of the current FFS system is unknown, although the number of services per physician has increased steadily over the past decade.

The first three of these patient concerns deal with their perception of the quality of care. The fourth is related to access. A FFS system without regional differentials in fees may make physicians less willing to set up practice in areas where there are high costs –costs that may include isolation and a hostile environment. Quebec has explicitly modified its

FFS system to provide higher rates of reimbursement for physicians who practice in underserviced areas.

b) Capitation payment

Capitation refers to a remuneration method in which a physician or group of physicians is reimbursed for the number of patients to whom they provide care, rather than for the number of services provided. Capitation also involves determining the reimbursement level for each person for whom care is provided. Capitation has always been associated with prospective payment in which the reimbursement level is related to the health needs of the individual. In general, health needs have been assessed in terms of age and sex.

I) Capitation has a number of options for the provider and the funder

As with FFS, capitation payment has a number of variants and prototypes. A physician "firm" can be paid on a capitation basis, although it may elect to pay its member physicians using FFS, capitation, or salaried methods, or some combination thereof. In Ontario, group practices that are paid capitation fees range in size from small two-member groups to very large groups, such as the group practice in Sault Ste. Marie. HSOs, the Ontario version of capitated practices, vary in terms of the range of activities provided, use of auxiliary personnel such as nurse practitioners and technicians, formal links with specialists, office hours, and populations served.

Although comparisons are often made between Ontario HSOs and their seemingly-related counterparts in the United States, Health Maintenance Organizations (HMO), there is actually little similarity between the two. It is true that both are paid on a capitation basis. But there the resemblance stops. HMOs explicitly include hosital care as part of their service structure, whereas in Ontario, hospitals are distinct from ambulatory practice groups and are funded on a different basis (global budgeting.) In the United States, HMO members who seek care outside the HMO are responsible for paying for that care; in Ontario, patients cannot be similarly "locked-in" to a single care provider or group of providers. As a result, many HSO patients use outside services and the HSO is financially penalized through a process known as "capitation negation." When a HSO patient uses a FFS provider to receive care that could have been obtained within the HSO, the HSO's monthly capitation payment for that patient is negated, i.e., withheld.

II) The ambulatory care incentive plan provides Ontario HSOs with financial payments for reduced hospitalization

Two other differences exist between the American and Canadian systems. First, the capitation rates for Canadian HSOs are based on existing (age-sex adjusted) FFS utilization rates (and hence charges) for the province. This system of capitation rate determination was designed to ensure that HSOs would not be financially disadvantaged relative to their FFS counterparts, and that alternative reimbursement methods would cost no more than the existing FFS system. The Ontario rate-setting process is different from utilization rates of their own members, not of the members of their competitors, the FFS sector. Secondly, in Ontario, HSOs receive a bonus, in the form of the Ambulatory Care Incentive Plan (ACIP), for reduced hospitalization rates. If the rates of hospital use for members of a specific HSO are lower than the rates for FFS patients in the same geographical area, a portion (approximately 40%) of the cost difference is returned to the HSO.

It is important to appreciate the differences between the U.S. and Ontario systems when one is assessing the impact of capitation payment. Although some of the U.S. experience with capitation may be generalizable to Ontario, much of it is not. The discussion below will nonetheless draw on some of this U.S. evidence, with the understanding that it should be interpreted with caution for the Canadian context.

Analysis of the Canadian experience is limited almost exclusively to the HSO at Sault Ste. Marie. This evidence substantiates many of the American results, but is also difficult to generalize to the HSO system as a whole because of the unique characteristics of the Sault Ste. Marie practice; e.g., large market share of the total Sault Ste. Marie patient population, union sponsorship, history of inception and development.

iii) Capitation offers advantages for physicians

The HSO mode of practice organization offers at least two potential advantages for physicians. First, because capitation payment is not linked to the number of type of services provided, physicians are freer to determine the content of their practices. Pressures to maintain or increase the volume of services in order to protect incomes are reduced. Moreover, service provision can be determined by the needs of the patient, without worry about the relative compensation rates for various procedures. The extent to which physicians practising in the HSOs actually do provide a different mix of services from their FFS counterparts is unknown. The results of a preliminary study, however, indicate that HSO physicians claim that they are providing more prevention and health promotion services, but that this claim is not supported by a comparison of the charts of HSO and FFS patients. The study relied on a small "convenience sample" of physicians; thus its results should be viewed as only preliminary.

The second advantage to physicians is that the method of capitation payment reduces the administrative workload of the practice. The claims submission process is simplified, administrative costs are reduced, and the stream of income payments is more predictable.

Although some Ontario physicians argue the virtues of the HSO model, the OMA has historically taken a skeptical, if not negative, view of capitation payment. It cites several reasons for its opposition. First, capitation payment recognizes different workload efforts only to the extent that these differences are reflected in the number of patients in each practice. In addition, because capitation payments are not adjusted for the health status (other than through the age-sex adjustment) of patients in any given HSO, practices with a relatively sicker patient population may be disadvantaged under the HSO system. This concern has led to recent research on methods for incorporating health status differentials into capitation payments.

The other major OMA concern is with the perceived implications of capitation funding. Specifically, a move from FFS to capitation reimbursement is seen by some to be indicative of a loss of freedom or control over medical practice. Presumably this fear arises because of the potential loss of a bargaining lever in the OMA's negotiations with the Ministry – the setting of fees. It is not clear why bargaining over capitation rates would provide less of a lever to the profession than bargaining over fees, but the fear remains nonetheless.

iv) Capitation has the potential incentive for under-servicing

From the patient's perspective perhaps the greatest concern about capitation payment is its potential incentive for under-servicing. It has been argued that, because capitation reimbursement is not linked to the number of services provided, HSO physicians may have an incentive to provide fewer services than FFS physicians, relative to patient needs. Herein lies a dilemma: from a patient's point of view, is it better under the FFS system to receive more services than might be necessary (with the resulting adverse effects of those unnecessary services,) or fewer services than needed (also with adverse effects, but different ones) under a capitation plan? This concern has prompted a wide debate on the implications of capitation payment for the quality of care. Evidence on the effects of payment mechanisms on quality of care is scant, and primarily U.S.-based. Generally, studies have indicated either no difference or mixed results, with both FFS and capitation plans showing superior performance on different outcome indicators. Studies that have found FFS care to be of higher quality have typically relied on process measures (eg., qualifications of personnel, financial liability of physicians) rather than actual patient outcomes to assess the quality of care.

Another concern for patients is the potential barriers to joining HSOs. Because HSOs are paid a flat capitation rate regardless of the health status of their enrollees, there is an incentive for HSOs to restrict their enrollment to relatively healthy people. If this were to happen, sicker patients would then be "dumped" on the FFS sector. (The cost implications of this scenario will be discussed below.) But the threat of what has been labelled "adverse selection" may be more perceived than real. The U.S. evidence provides little support for the adverse selection theory, but it is admittedly difficult to measure. There has been no systematic study comparing the care requirements of HSO versus FFS patients in Ontario, although five of the 32 HSOs are attached to teaching hospitals, which typically have a more complex case mix than non-teaching FFS practices.

The lack of continuity of care provided by capitated practices has also been raised as a potential drawback to the approach. Because HSOs typically consist of several physicians practising as a group, the chances of a patient seeing more than one physician during an episode of care or over several episodes of care are obviously greater than if the patient seeks care from a solo FFS practitioner. This discontinuity of care is sometimes wrongly attributed to the type of reimbursement rather than the organization of the practice (e.g., solo versus group). FFS physicians can practice in groups just as easily as their capitation-reimbursed counterparts. Indeed, Ontario has several examples of group practices reimbursed on a FFS basis. Similarly, solo practitioners may be paid on a capitation basis; the method of payment need not be linked to the size of the practice. Furthermore, many HSOs attempt to assign patients to particular physicians so that continuity of care can be maintained. To the extent that continuity of care is an issue for patients, it is an issue of practice size, not of payment method.

A potential advantage for patients in capitated practices is that they have access to a greater variety of services and health care providers. In theory at least, capitation provides an incentive

for physicians to keep their patients healthy. This suggests that physicians paid under capitation might provide more health promotion and disease prevention services than physicians in a FFS system.

v) Capitation provides incentives for cost-savings

Capitation payment is frequently advocated because of its potential for reducing costs. In an era of increasing expenditures and simultaneous pressures for fiscal restraint, it is not surprising that the Ministry has taken great interest in capitation payment as an alternative to the predominant FFS system. Evidence from both Sault Ste. Marie and the U.S. suggests that capitation funding has the potential to reduce expenditures significantly, primarily through the reduction of hospital use. But will these savings be realized to the same extent (if at all) in a system as different as that in Ontario? There are at least two reasons to suspect that the results are not directly transportable across borders.

First, the Ambulatory Care Incentive Program transfers a portion of the HSO's savings from reduced hospitalization directly back to the HSO. Therefore, although the potential to reduce total expenditures exists, the reduction in actual expenditures is not as great as it might be in the absence of ACIP. This is not to say that ACIP does not serve a useful function –it provides financial incentives to HSOs to curtail the hospital use of their enrollees. But the existence of ACIP does limit the savings potential of HSOs.

The second reason that Ontario HSOs might not achieve the savings success of HMOs in the U.S. is that, as discussed earlier, capitation payments in Ontario are based on prevailing FFS utilization rates. In effect, this means that the payments to the (hypothetically) lower cost HSO sector are based on the billings of the higher cost FFS sector. As long as physicians in the FFS sector do not change their billing patterns, capitation payments will be based on FFS practice style.

The implications of this method of capitation rate determination are even more severe in the presence of adverse selection. Should the practice of adverse selection exist in Ontario HSOs, sicker patients would be left to be treated by FFS physicians. This would raise the costs of care in the FFS sector which would in turn raise the capitation rate for the HSO sector. The overall effect would be a perverse situation in which HSOs cared for a healthier segment of the population, and were reimbursed at increasingly higher rates for this care.

From a government point of view, capitation payment is administratively easier than FFS, but generates fewer data on the types and volume of services provided. Review of individual physicians' practice patterns becomes more complicated and time-consuming (a problem which is probably more consequential for the College of Physicians and Surgeons than for the Ministry,) as does monitoring overall trends in the pattern of care over time. This does not imply that these tasks could never be carried out in a capitation-based reimbursement system, merely that they would be difficult to undertake on a regular basis with the existing HSO data collection system.

By providing higher capitation rates for populations in areas with an undersupply of physicians, the government could provide a strong economic signal for physicians to move to those areas.

The extent to which the government supports and encourages the expansion of capitation payment will be determined, to a large degree, on the ability of capitated practices to reduce costs while maintaining or improving quality of care. Results from other jurisdictions show great promise for a capitation payment system, and the limited results from Ontario are positive. But further study and analysis of the diverse Ontario HSO system and its peculiarities is necessary to determine more conclusively the actual costs and benefits of HSOs.

c) Salaried payment

Salaried payment refers to a method of reimbursement in which physicians are paid a predetermined income for a specified work schedule, regardless of the number of services provided or patients seen. Salaries are set prospectively and the rate of remuneration is determined through some form of bargaining.

Because salaried payment resembles capitation in that the physician's income is not a function of the number of services provided, many of the arguments for and against salary are similar to those discussed in the previous section on capitation. But the analysis of salaried payment is in some ways more difficult than that of either FFS or capitation. The difficulty arises because the motivation and incentives for salaried physicians are very much determined by the kind of organization in which the physician practises. Different institutions and organizations have different policies regarding the number of patients seen, the types of services provided, the use of high technology and ancillary services, the use (and availability) of support personnel, etc. At best, therefore, it is possible to make only broad generalizations about the impact and effects of salaried payment, while keeping in mind that any of these effects could be altered by a particular practice environment.

Physicians who practise on a salaried basis tend to do so because of their preference, all other things considered, for working in a particular environment such as hospital or CHC. Consequently, the concerns about salaried payment tend to come not from physicians who are salaried, but from the FFS sector that perceives a growing trend toward salaried reimbursement. This trend, they fear, indicates a shift from self-employment to civil service employment – something alarming for a group that has historically distrusted government and all its trappings.

An alternative interpretation of the OMA's stance against salaried practice is that it does not disparage the existing situation, but rather seeks to ensure that physicians will always have freedom of choice about payment method. Consequently, any pressure to increase the extent of salaried payment relative to FFS is viewed as a step toward losing that freedom of choice.

i) Salary systems prevent individual physicians from determining their income levels

The disadvantages of salary for an individual physician is that he/she is unable to determine income levels directly. It is of course possible to negotiate over wages with the institution that employs the physician, but once salary levels are set, annual incomes are also set. The advantage of salaried reimbursement is that it eliminates the

administrative costs of filing billing claims and dealing with OHIP overpayments.

Salaried reimbursement has been criticized for its incentives to underservice patients, reduce physician workload, and discourage continuity of care, all of which directly affect patients. These allegations have not been borne out by scientific study, primarily because few studies have been conducted comparing salary with FFS or capitation. One U.S. randomized trial comparing FFS and salaried physicians found that the FFS group scheduled more visits per patient than did the salaried group, and saw their patients more often. The higher number of visits, however, was attributable almost entirely to more well-baby care.

The U.K. experience with salaried practice has often been used to support the charge that a salaried setting encourages more referrals amongst physicians in an attempt to reduce workloads. Patients seeking care from specialists in the U.K. often face long waiting times and queues for diagnostic and therapeutic procedures. The extent to which this is a result of salaried payment per se versus other systematic factors is not clear.

ii) A salaried system has advantages

A salaried system has two advantages from a funding perspective. First, the government is better able to control expenditures and budget accordingly when physicians are paid on a salaried basis. Unlike FFS, in which the volume of services has (at least in the past) been beyond the control of the government, or capitation where rates are based on FFS charges, a salaried system provides an extra measure of predictability and control of expenditures. Notwithstanding, the total costs of a salaried system may exceed those of either FFS or capitation, depending upon salary levels.

The second advantage to a funding agency is the administrative ease of a salaried system. The payment process is facilitated and the need for maintaining huge procedure-specific data bases is eliminated. But this benefit must be weighed against the cost of losing valuable research data, or alternatively, of designing a data collection system that would provide necessary information and updates.

d) A mixed reimbursement system

The preceding discussion focuses on each payment mechanism in isolation from the others. But in all likelihood the Ontario system will never exclusively employ any one payment method. Thus, a relevant policy question might focus on the ways in which these alternative payment systems might operate in conjunction with one another, rather than in isolation. It has been suggested that greater savings and improvements in quality of care might arise from the competitive aspect of interactions rather than from a specific reimbursement method. This implies that no one system is best. Moreover, a system that supports and promotes alternative reimbursement mechanisms for physicians would provide both consumers and providers with more options and a broader scope for choice. The domination of a health care system by a single type of reimbursement, as in Ontario, forces many providers and consumers to work within a system that does not meet their goals and ambitions.

Building on this theme, U.S. analysts have suggested that an optimal reimbursement strategy might allow individual physicians to receive payment using all three methods. Dubbed the "three layer cake" approach, it bears some resemblance to the current British payment system. Although this approach is not likely to be a candidate for immediate implementation in Canada, it suggests that policy initiatives should be targeted at examining ways to capture the strengths of each payment system, such that physicians, patients and government alike can share in the benefits.

e) Implications for Ontario

The debate has gone on for a long time about how best to remunerate physicians in an effort to satisfy the needs and demands of patients, payers and physicians alike. The debate has been fuelled by a mixture of evidence, anecdotes and ideology, with various actors in the health care system staunchly defending their positions and preferences. Perhaps one of the reasons that controversy about payment mechanisms thrives is because no one system is clearly optimal, regardless of one's viewpoint or ideological starting positions. Each payment approach has a mixture of advantages and disadvantages, both perceived and real. Each payment system can be modified to meet either general or specific goals. It is not surprising, therefore, that no one approach has emerged as "the best" or that consensus is lacking on how to structure future public or professional policies on physician payment methods.

Any physician reimbursement alternative, including maintenance of the status quo, is likely to have an effect on the pattern of services provided. In turn, the mix of services provided will have an impact on health status. Although, ideally, a reimbursement system should be directly linked to health status outcomes rather than services provided, that link is not easy to make. Thus, it is important to provide a mechanism, other than reimbursement itself, to ensure that quality of care goals are attained. Quality of care assessment and quality of care assurance are areas that clearly need to be bolstered if the provincial government hopes to develop, implement and evaluate promising health care policy options.

The existing health care system in Ontario is dominated by a FFS reimbursement of physicians that allows the provincial government little control over the amount or mix of services provided. In the short run, significant changes in reimbursement policy are most feasible within FFS (e.g., utilization controls, modification of relative prices.) In the longer term, changes could involve meaningful commitment to alternatives to FFS. A mixed system of reimbursement mechanisms may be the best alternative, in both practical and theoretical terms.

D. HOSPITAL OPERATIONS

1. With global budgeting Ontario hospitals have experienced relatively stable costs

Since 1969, Ontario has had a system of global budgeting of hospital operating expenditures. Over that period, hospital expenditures have remained relatively stable in real (inflation-adjusted) dollar terms and as a percentage of gross provincial product. This history of cost control for hospital operating expenditures stands in stark contrast to the rapidly increasing cost of physician services. While the control of hospital expenditures may be laudable, it should not be forgotten that provincial government hospital operating expenditures are the largest component of the MOH budget, coming to over $5 billion in 1987-88. Further, it should be noted that

Ontario has a rate of hospitalization (measured as patient days per capita) that is much higher than other jurisdictions, such as the U.S. and some European countries. Thus, though hospital expenditures may not have grown rapidly in recent years, the government is still concerned with the magnitude of those expenditures and the dependence of our health care system on institutional care.

The existing global budgeting system requires a minimum amount of management by the government itself. The key management task of ensuring that hospital funds are spent efficiently is left almost entirely to the hospital. From the government perspective, this policy works quite well as long as hospitals provide the services required by patients and demanded by physicians –while working within their budgets. In recent years, however, the government has had to face the situation where more and more hospitals incur deficits. When a hospital spends more than its budget allocation the key question becomes whether the hospital was:

- Under-funded for the level of services it was required to provide;
- Appropriately funded, but inefficiently managed.

Without some basic measures of demand and efficiency that question is very difficult to address.

On one hand, when hospitals consistently incur deficits, the government has to wonder if those hospitals are attempting to circumvent an effective prospective payment system. On the other hand, hospitals that consistently are not able to meet service requirements have to wonder if the government is indifferent to real funding needs. This tension between hospitals and the provincial government is an increasingly important issue in hospital reimbursement.

a) The relationship between hospital management and physicians is important

Another important issue is the effect of hospital reimbursement mechanisms on the relationship between hospital administrators and the physicians who practise in the hospital. Hospital administrators are charged with the task of prudently managing the hospital's resources, but physicians hold much of the control over the types and levels of services that patients receive in that hospital. This implies that a key to the efficient operation of hospitals is the development of an environment that fosters cooperation between administrators and physicians, rather than confrontation. Since the characteristics of a hospital reimbursement mechanism can have important impacts on the management and information structure of the hospital, these mechanisms can affect the environment in which both managers and physicians work. A well-designed hospital reimbursement mechanism has to take into account the effect of reimbursement on that environment.

b) Hospital reimbursement should encourage the shift to community care

While the inpatient care component of hospitals may be the centrepiece of the existing health care system, the changing nature of health care needs suggests greater use of non-institutional services is the way of the future. Existing hospital reimbursement policy has tended to focus on the care within the four walls of hospitals themselves, rather than on the relationship between the acute care component and community-based care. Given the changing nature of the health care system, there is a need to develop reimbursement mechanisms or organizational structures that would promote coordination of the institutional-based and community-based care.

The following discussion of hospital reimbursement mechanisms attempts to identify the major alternatives and their impacts on hospital cost, hospital efficiency and the relationship between hospital managers and physicians. In response to concerns over the need to better coordinate acute care hospital services with other services, the impact of reimbursement mechanisms on such cooperation is discussed.

2. Reimbursement alternatives and their effects

a) An itemized payment system charges for each service received by a patient

In an itemized payment system the individual inputs received by the patient during a hospital stay form the basis for reimbursement. There is a great deal of latitude in the degree to which services might be bundled in such a system. For example, charges may be itemized for the daily room rate, a number of different ancillary services (e.g., lab tests, pharmacy) and physician's fees (generally for those not salaried by the hospital). Although hospitals may itemize dozens of separate charges, third-party payers usually choose to reimburse hospitals at different levels of aggregation. For instance, in the U.S., Blue Cross plans often pay an average per diem across all of its patients for ancillary services. That is, these plans do not reimburse hospitals different amounts dependent on the size of the itemized ancillary charges. Some smaller, commercial insurance companies may actually pay the full itemized charge (or have their policyholders pay and then reimburse them) for each bill.

Itemized-charge systems can be based either on prospective payment or retrospective payment. In a prospective system the payer and the institution agree to certain prices (e.g., a charge for daily room rate) that are held to for a period of time. More commonly, charges are set retrospectively and a hospital will submit charges that reflect its costs for producing those services.

i) Itemized payment systems are complicated and don't reduce costs

Generally, reliance on itemized charges as a payment mechanism both complicates the payment process and does little to reduce cost growth. Unless the payer reimburses the full charge for each itemized service, the monitoring costs of such a system are high relative to payment using an all-inclusive mechanism. At least in the U.S., itemized payment has generally allowed hospitals flexibility to escape the full rigours of prospective payment systems. For instance, the ability to bill separately for outpatient and physician services provides incentives for physicians to complete such tasks outside the hospital where rate setting controls are less rigorous. The unbundling of medical services typically provided in the hospital (e.g. MRI or CT scans) to outpatient services has been the most dramatic impact of the U.S.'s latest attempt to regulate inpatient hospital operating costs. As a result, outpatient costs (through the ability to separately itemize charges outside the hospital) have increased dramatically, blunting the ability of the U.S. to control per capita health care expenditures.

Payment of a number of separately itemized charges complicates the task of payers interested in reimbursing providers based on some measure of true cost. For each separately itemized charge, some base measure of cost is required. In the case of the U.S., this has most recently been manifested through the completion of a substantial volume of

work aimed at developing a resource-based relative value scale for payment (based on the input costs of providing medical services).

An itemized-charge system does not provide incentives for either hospital managers or physicians to provide a cost-effective mix of services. Revenues of the hospital are increased with increasing service levels. The hospital is unlikely to encourage physicians to practise in a resource-conscious manner. If sophisticated and expensive services are reimbursed by payers, then hospitals do little to ensure that physicians use those services with due selectivity.

The incentives for coordination of services under an itemized charge system are somewhat perverse. From the government's viewpoint, cooperation should ideally result in patients receiving more appropriate and hopefully less expensive services than those available in the acute care institution. However, as seen in the U.S., very expensive services (e.g. CAT scans) can be provided outside the acute care hospital. Therefore, itemized charges can lead to increased use of outpatient services with no reduction, and perhaps even an increase, in total expenditures.

b) Daily charges simplify the funding system but don't recognize the individual cost differences

A daily charge or per diem system of hospital reimbursement is based on a patient day. In general, the per diem charges represent some average measure of daily room and ancillary charges over a defined population. Theoretically, setting daily charges is quite simple. The total costs of providing care over a period of time is simply divided by the number of patient days in that period. The practical difficulty comes in measuring the true costs of care.

From the hospital's perspective, use of a daily charge eliminates the need to identify costs for each patient. Instead, based on the projected expenditures over the coming year (along with expected volume), the hospital financial manager can set a charge structure that allows the hospital to meet its financial requirements. Reimbursement based on hospitals setting prices allows charges for the provision of hospital services to drift away from true costs. Use of daily charges also provides little pressure on hospitals to reduce length of hospital stay and utilization of clinical support services. As a result, reliance on charges (generally reimbursed retrospectively) has often been associated with high rates of spending growth by third-party payers in most countries.

If the government were to set charges, then it would have to have detailed information on the cost structure within the hospital. This level of detailed information is not inexpensive to collect. However, even if a per diem reimbursement system were linked to a measure of true costs, it still might not promote cost-effective use of hospital resources. The incentive under a per diem system is to increase the length of stay while controlling the number of services provided during each day of that stay. There is no direct incentive to control the total number of services provided.

i) Daily charges have an indirect incentive to increase length of stay

Physicians practising in hospitals that are reimbursed on a per diem basis might be encouraged to modify some facets of the utilization pattern, but they would not necessarily be encouraged to

control the levels of utilization. For example, given that the cost per patient day tends to decrease as the length of stay increases, physicians might not be under much pressure to reduce lengths of stay – although there might well be attempts to induce them to reduce utilization of specific services. Perhaps more significantly, the hospital administration might not be particularly interested in removing long-stay patients that are referred to as "bed blockers." To the hospital administrator, these patients are financially attractive because they generate relatively low cost patient days compared to the costs that might be generated by new admissions. To the physician, these patients are seen to be tying up beds that could be used by more acutely ill patients.

In general, per diem reimbursements of acute care hospitals does not provide direct incentives for the more appropriate use of other health services. The fact that acute care hospital administrators under a per diem system might not be interested in moving long-stay patients to other institutions could reduce demand for long-term care services, but this decreased demand would only come at the expense of those patients receiving care in a higher-cost institution. There is, however, potential to modify simple per diem reimbursement to promote more appropriate utilization of alternative health services. For example, restrictions could be placed on reimburseable length of stay, or the per diem charge could be related to the length of stay.

c) Case payment systems base the reimbursement on treated cases

Case payment provide a major conceptual shift in reimbursement policy compared to itemized charges or per diems. Both of these systems base reimbursement on resource inputs. Case payment bases reimbursement on an output – a treated case. While case payment rates could be set retrospectively, the most common approach is to set these rates prospectively.

Use of prospective case payment for hospitals is designed to provide incentives for hospitals to monitor their costs of providing care. Since payment rates per case are fixed, the ability of a hospital to break even depends on its ability to understand the relationship between its own cost structure and treatment patterns. In general, this would provide incentives to monitor length of stay as well as the ancillary inputs to care.

The actual payment to hospitals can be quite simple or quite complicated. It first requires the definition of an acceptable classification system for the unit payment. An ideal system would have a limited number of categories that were defined across clinically meaningful dimensions. The cost variations within each category should be narrow enough to allow for accurate price setting. While no ideal system has yet been created, the most popular classification system is the Diagnosis Related Group (DRG) system developed in the U.S. The basic features of the DRG system have been used to develop a Canadian system called Case Mix Groups (CMG). The CMGs measure hospital output by classifying patients into 23 major clinical categories (MCCs) based on the major body systems affected by the disease process. The MCCs are divided further into 471 CMGs based on the patient's specific diagnosis or surgical procedure used, and upon age and other clinical information (especially the existence of complications).

I) Hospitals can be funded using a hospital specific payment or an industry price

Two methods could be used to reimburse hospitals under a DRG system; a hospital specific payment, or the use of a "price." A hospital specific system would simply pay each hospital a set fee based on the average cost within that hospital for each DRG category. Alternatively, one could make use of a pricing system such as the one used by Medicare in the U.S. Under this pricing system reimbursement is based on some average cost for each DRG times a "standardized" cost per discharge for each hospital. The standardization process adjusts hospital costs for differences in area wages, teaching intensity and other factors. Note that under a pricing system, average payments for some hospitals will be less than average cost, while for others above average costs. The redistributive aspect of the system has generated some controversy.

Use of a pricing system is designed to reward efficient hospitals (those with payments at or above costs) and penalize inefficient hospitals. Clearly, the ability to accurately measure efficiencies through the standardization process noted above is a central design issue. Major goals of a pricing system are to encourage hospitals to "specialize" in areas where they are clearly more efficient and have a comparative advantage. Moreover, there is a clear incentive for hospitals with payments set below costs to reduce length of stay and ancillary intensiveness. This has led to some concern that patients would be discharged too early, or discharged and subsequently readmitted after a short period of time.

II) The DRG payment system in the U.S. has had mixed results

The early results of the DRG payment system in the U.S. have been mixed. Some of the expected effects of the system have been realized. Average lengths of stay has for Medicare patients decreased from 10 days to slightly under 9 days, despite an increase in the acuity of hospitalized patients. Moreover, the rate of increase in Medicare operating costs has slowed down. Slower cost growth appears limited, however, to those hospitals with payment rates set below their average operating costs. Hospitals with improved operating margins under the system (i.e. those with payments set above costs) have reinvested a portion of their surplus, resulting in higher rates of cost growth in these hospitals.

By design, the Medicare-DRG system provides incentives to move services from inpatient settings to ambulatory sites. Under the DRG system, there has been a rapid rise in the volume of ambulatory visits, procedures and surgical procedures. As a result, ambulatory care costs have increased sharply, blunting potential savings. Because the DRG system is at present limited to acute care instututions, there are concerns that it will put increasing pressure on long-term care and community services. Decreasing lengths of stay may be associated with the release of patients who require higher levels of support than previously observed.

Reimbursement on a case-payment basis puts pressure on hospitals to carefully examine cost patterns within each case category. If the categories are designed to be clinically meaningful, it may be

possible for hospital managers to more easily communicate their cost concerns to physicians. Since the introduction of the Medicare-DRG reimbursement mechanism in the U.S., there has been a rapid growth in the use of hospital information systems that can be used to identify cost patterns of individual physicians. The impact of these systems on physician behaviour has never been properly evaluated. But it is clear that the Medicare-DRG system has had a large impact on hospital management in general, and particularly on the relationship between the hospital manager and the physician.

d) Capitation systems are administratively simple and have the built-in incentive to keep patients healthy

Capitation entails reimbursing the hospital in advance (or in the case of an HMO, the plan) for the care of a defined population over a defined time period. At the hospital level, such systems are easy to implement if one payer (usually the government) provides the bulk of the hospital's revenue. The system is administratively simple to operate. Payments are not based on individual "bills" or charges, adding simplicity to the system. The downside of this arrangement is the loss of information and attention paid to hospital "production" costs. Payments are based on the number of people covered, usually with some form of adjustment for the health needs of the population.

The capitation system is conceptually different from the case-payment system in that it is based on a contract guaranteeing service coverage, not on the actual production of services. The incentive is to keep the patients healthy and satisfied, but not necessarily to provide them with hospital services. Because ambulatory services can act as a less costly substitute for hospital services, organizations funded under a capitation system generally include both hospital and ambulatory care components. Perhaps the best known capitation system is the Health Maintenance Organization (HMO) in the U.S.

A key feature of HMO is the integration of the traditional insurance and health care delivery function within one organization. The four essential elements of an HMO are:

- HMO assumes contractual responsibility for assuring the delivery of a range of health care services, including at least inpatient hospital and ambulatory services;
- HMO services a voluntarily enrolled population;
- HMO enrollee pays a fixed annual or monthly payment, independent of use of services. In some cases, small cost-sharing charges are used;
- HMO assumes some of the financial risk or gain in the provision of medical care services.

Each of these features demonstrates important differences between HMOs and other payment mechanisms described above. The HMO, as the entity at risk for provision of services, has incentives to minimize costs by reducing the future demand for medical care services. The potential emphasis on wellness and prevention made the HMO concept a promising method for delivering quality health care at reasonable cost. Of course, the same incentives HMOs have to reduce future demand for services may, some critics contend, also result in less-than-optimal medical care and the "cream-skimming" of healthy patients. At least in the U.S., there is some support for the latter contention and little for the former.

In addition to the implied promise of emphasizing preventive care HMOs have been highly touted as a method for containing

costs. The recent increase in health care costs is due not only to the growth in medical technology and general inflation, but also to an absence of appropriate and less costly alternatives to hospital care.

l) HMOs have reduced the cost of health care

In practice, HMOs have been shown to reduce the cost of health care. One recent study by the Rand Corporation found that HMOs result in 28% lower expenditures relative to a first-dollar coverage, fee-for-service plan (a plan very similar to Canada's). The lower expenditures were almost all from decreased hospital costs. Some question remains as to whether these reductions represent one-time savings or are continuing. Recent studies appear to indicate that, after their initial savings, HMO costs resume the same rate of growth as that of other health care delivery alternatives.

Physicians who work in HMOs can be reimbursed by the HMO in a variety of ways. Some HMOs reimburse on a FFS basis with a cap on expenditures or some prorating of fees to control overutilization. Other HMOs set up an agreement with a group practice in which the group practice allocates funds to physicians. Finally, some HMOs hire physicians directly on salary. The details of the relationship between the HMO managers and physicians are in large part dictated by the specific reimbursement mechanism employed, but the general incentive is for physicians and managers to work together to provide cost-effective care. Since it has been shown that the cost savings generated by HMOs are the result of decreased use of acute care hospitals, the major focus of cooperation between managers and physicians is in HMOs appears to be the use of alternative source of care. Presently, most HMOs provide coverage for ambulatory care and acute hospital care so there is little evidence on the ability of this type of organization to lead to more appropriate long-term or chronic care. The concept of a social HMO, which explicitly includes both long-term and broad-based community services, has been developed in the U.S. But the definitive evaluation of that alternative has not been completed.

e) The present global budgeting system could be adapted to use measures of output

To this point, hospital reimbursement mechanisms have been discussed in the context of a system with a direct link between the unit of reimbursement and the hospital budget. Whatever the unit, the total operating budget is simply the sum of those units times the price per unit. In the existing Ontario global budgeting system, there is no direct link between service or output units and the budget. The size of the budget and the number of services provided are clearly related, but that relationship (other than a limited amount of growth funding based on a crude measure of patient days) is not explicit.

Alternatives to the existing global budgeting system could take two forms:

- Abandonment of the existing global budgeting replacing it with a system in which funding is based directly on productivity or output;
- Modification of the existing global budgets by incorporating some explicit adjustment for productivity or output.

One adjustment process would involve the use of one of the measures of output (e.g., services produced, days of care, cases treated or patients covered) to provide a

measure of productivity that could be used to modify the budget allocated under the global budgeting system. For example, an overall measure of cases treated by a hospital along with the budget allocated to the hospital could be used to generate a productivity measure – cost per case. The global budget for the hospital could be based on the previous year's budget, along with some adjustments for productivity. Alternatively, budget adjustment could be made on a peer group mean, not on the individual hospital's operation. Also, a preference could be given to low cost hospitals for new program developments. Another adjustment process could involve specific reimbursement for certain defined outputs or services. This adjustment process is similar to the current funding of life support programs as separate components of the hospital budget. Services or outputs that the government felt should be encouraged or discouraged could be identified and funded under mechanisms separate from the global budget.

3. Implications for Ontario

The global budgeting system for hospital operating budgets has been associated with reasonable control of expenditure increases in Ontario. However, the government has goals beyond simply controlling cost growth and hospital managers and physicians have expressed concerns over the impacts of global budgeting.

Other jurisdications have developed a range of different mechanisms for funding hospitals. These mechanisms are all based on the definition of a unit of hospital service produced. In general, these mechanisms are not combined with global budgeting, but involve payment directly for services produced. There is, however, no reason why these mechanisms could not be combined with global budgeting in order to both control cost increases and link funding to productivity.

The linkage of funding to productivity could make hospital funding more equitable than it is now. In 1983, all hospital base budgets were "locked-in"; since then global budgets have been linked to the previous year's expenditures. To a large extent, hospitals that are inefficient receive the same level of increase as their more efficient peers. If the inefficient hospital was able to obtain an adequate budget in 1983, it has been under little pressure to improve its performance. If the hospital was very efficiently run in 1983, but faces new demands, it may find it difficult to obtain the budget increases it requires. Some measure of productivity applied to the point when hospital budgets were locked-in and continued year to year, could result in a more equitable distribution of scarce resources. The government may not face much opposition from hospitals in modifying the existing global budgeting system. The Ontario Hospital Association has expressed the need for more realistic cost measures and specifically recognizes the importance of case mix in determining hospital budgets.

The development of a hospital budgeting system more closely related to productivity could make it easier to deal with hospitals that incurred deficits. If the productivity measure showed the hospital to be inefficient, then it might be very difficult for the hospital to argue that it was under-funded. Alternatively, if the productivity measure showed that the hospital was relatively efficient, it might be difficult for the government to argue that funding was appropriate. Inherent in the discussion of productivity measures is the notion that the type of measure (e.g., itemized services, days, cases treated, patients covered) chosen could be a major determinant of the incentives faced by the hospital.

A central issue in the improved performance of hospitals is the creation of an environment where it is possible for hospital managers and physicians to work together. Hospital reimbursement mechanisms can foster favourable environments for cooperation, but other policies may have to be developed to ensure such cooperation. For example, the establishment of clinical budgeting, in which medical staff take an active role in resource allocation, may be easier to promote under case-based reimbursement, but such a system can only develop through changes in the organization and structure of the hospital.

4. The funding system must be designed to move towards community-based care

By world standards, Ontario relies very heavily on institutional care A major challenge facing the government is develop techniques for reducing dependence on expensive inpatient-care hospitals, while promoting the use of less costly institutional and community-based services. Hospital reimbursement techniques can be designed to move them towards more community based care. However, it may be possible to create more direct and controllable effects on the coordination of hospital services and other services by focusing reimbursement policy at an organizational level that is more comprehensive than the individual hospital. This level of organization may involve vertical integration of hospitals with other services or the establishment of a local health authority or C.H.O. that would have control over the funding of all health care services.

E. EXTENDED CARE

1. Introduction

In the Province of Ontario extended care service is provided by two different systems. Homes for the aged are funded through the Ministry of Community and Social Services. Nursing homes are funded and controlled through the Ministry of Health. The funding of these two programs is significantly different.

2. Homes for the aged originally provided only residential care

When the two programs were initiated, the nursing homes provided extended care coverage and homes for the aged provided residential coverage. However, as residents in Homes For The Aged became older their physical conditions often deteriorated. As a result, their coverage requirements advanced beyond the residential levels to the extended care levels. The option was to move these residents from the home for the aged to a nursing home to provide the required coverage. As the clients were long-term residents in the home for the aged, it seemed more ethical to provide the extended care coverage in their existing place of residence. The physical facility, in most cases, was adequate to provide this level of coverage. All that was required was the additional staffing support to provide a continuity of care. At present approximately 50% of the clients in homes for the aged are extended care and 50% are residential. The homes for the aged have about 14,000 extended care patients and the nursing homes almost 30,000.

3. The funding of the two programs is very different

The important issue in this discussion is the funding the two services. Essentially the method is the same for the two areas. A fee for service is paid by the government (either the Ministry of Health or the Ministry of Community and Social Services) for each patient covered by extended care. In addition, a co-payment charge is paid by the resident. If the resident is unable to provide this payment it is covered by an additional transfer payment from either ministry. Within these similar payment mechanisms there are significant differences. Nursing homes are operated mainly by for-profit

private organizations. As a result any cost over-runs must be covered by the owners. On the other hand, homes for the aged, which are municipally run, are supported through the municipality and the provincial government for any cost over-runs. Similarly, homes for the aged that are operated by a charitable organization are provided additional support for over-runs through the charities and the provincial government.

The following discussion in section F of this chapter on capital funding addresses the inappropriate placement of patients. The implication of this is that additional extended care beds will be required to realign the placement of patients within the system.

If the per diem method of funding is appropriate for the extended care program then, as with the hospital-based system there is a need to recognize differences in case mix and program structure.

F. CAPITAL FUNDING

1. Introduction

Funding of capital costs for new contruction, renovations, or new equipment has long been one of the more contentious issues in the Ontario health scene. Existing methods of funding capital costs need to be re-examined. Priorities need to be established – consistent with overall objectives. Changes should be considered in order to provide incentives and to control the means by which funds are allocated for capital projects.

2. Existing funding regulations are inconsistent -- even within the Public Hospitals Act

Within Ontario the major capital expenditures of the Ministry of Health relate to financial support for the construction, renovation, and equipment of hospitals. The regulations under the Public Hospitals Act allow the Ministry to pay up to 2/3 of the "approved cost" for most hospital projects. However, in municipalities in Northern Ontario, where the population is 12,000 persons or less, the Ministry may pay up to maximum of 5/6 of "approved costs."

In this connection, the question of "approved cost" may be quite significant. These costs include the cost of construction or renovation, fees to architects and consultants and approved equipment. The cost of land survey, soil tests and paving of driveways and sodding is also included. However, the "approved costs" do not include a number of items including such things as land acquisition: financing charges, contingency allowances: landscaping, gardens, works of art, replacement of existing equipment; and paving of a parking lot. These additional costs must be financed by the hospital itself in addition to its one-third share of costs.

The various regulations under the Public Hospitals Act relating to capital costs embrace a range of cost sharing arrangements.

An example is the capital grants for ambulance facilities. For such facilities the ministry pays 100% of the cost. However, financing charges, working capital, contingency allowances, and landscaping gardens, etc., are not included. Curiously, however, the Ministry may pay for the cost of land for an ambulance facility.

In another instance, the Ministry can pay 100% of "approved costs" for "capital expenditures that would produce savings and operating costs" (Regulation 858).

Even within the capital funding for hospitals and related facilities, therefore, we are left with a diverse range of payments that may be made for a capital project and differences in what is included or excluded from capital costs.

3. How are other facilities or programs funded?

Generally, the Ministry does not directly provide capital funds for other facilities/ programs. However, through a variety of means it would seem that it does, essentially, fund up to 100% of capital costs.

Consider a number of examples:

a) Community health centres

For community health centres the Ministry provides a global budget. Included in that global budget is an allowance for rent. No doubt the landlord of the building ensures that the rent covers the cost of land, construction, financing charges and profit. The community health centre does not have to provide any capital funds itself. In addition, where equipment is approved by the Ministry, 100% of the capital cost is picked up through the line-by-line operating budget mechanism;

b) Nursing homes

The Ministry approves a per diem rate for the care of residents in nursing homes. Part of this is paid by the resident and the government pays the balance of the resident's daily charge.

The owner of the nursing home must meet both operating and capital costs from the per diem rate. One may assume, therefore, that the cost of land, building, financing costs, etc. are being funded through the per diem rate;

c) Physicians' offices

Physicians operating as independent practitioners, on fee for service, do not receive specific capital funding from the government. The cost of their office space, equipment and other capital cost must therefore be met from the revenues they get (as a general rule) from OHIP. Thus, in the case of a fee-for-service payment mechanism the revenues generated have to be used, in part, to pay for the cost of facilities and equipment. In essence, therefore, one may assume that 100% of capital costs are being met indirectly through the OHIP fees. Clearly, no identifiable component of the fee can be attributed to capital costs. How could it be so when the range of facilities, rents, etc. vary so significantly across the province?

4. The Ontario Hospital Association projects a need for additional capital funding

In a recent publication, Hospital Capital Funds – Health in the Balance, the Ontario Hospital Association commented on the need for added funding for hospitals in Ontario. It noted in 1986 that the Ontario government committed $850 million over a period of years for hospital capital costs. However, the OHA has estimated that the capital needs are some $550 million a year.

To deal with this, the OHA notes that hospitals have three sources of funds:

- Surpluses in operating budgets;
- Community fund raising, including municipal government grants;
- Private sector financing/market borrowing.

With regard to each of these, the OHA's report notes that the Ministry of Health has recommended that capital reserves be built from operating surpluses. The OHA recommends individual hospitals set aside 2% of the operating budget for capital purposes.

With regard to community fund raising, hospitals appear to have increased their efforts. However, support by municipalities for hospital capital needs is inconsistent.

5. Capital planning commitment should be reassessed

The Ministry's $850 million capital program announced in 1986 visualized the addition of about 3,600 beds. Of these, about 2,400

would be chronic and 1,200 acute. We understand that the estimated costs of these commitments has escalated, perhaps to double the original $850 million plan. At the same time, developments have taken place in the health care field. The increasing emphasis on ambulatory and community-based services certainly suggests that the original commitments should be re-assessed.

Based on many accommodation studies that have been undertaken by District Health Councils over the years, our health care system does not succeed in placing people in the right level of accommodation as often as might be desired. Indeed, there are some suggestions that about 10% of all acute care beds and 25% of all chronic beds are occupied by patients who should be placed elsewhere. Most often these "inappropriately placed" patients should be in a lower-cost level of accommodation. In other words, a patient may be occupying an acute care bed when his or her condition really requires only a chronic or extended care bed. Indeed, it is not at all unusual to find people in institutions who might be at home if there were appropriate home care and support services.

Comparisons with other countries should be reviewed with caution. However, in the United States the ratio of patient days per 1000 population is about 25% lower than in Canada. Taken together with the various accommodation studies that have been conducted, as well as the frequent publicity to "bed blockers," there may be an opportunity to substitute the investments planned in the 1986 announcement with initiatives for lower levels of care.

For example, if capital expenditures could be diverted into providing extended care rather than chronic or acute care beds, total costs could be reduced. Or, alternatively, more beds could be provided for the same money. (It costs considerably less to provide extended care beds than beds in chronic or acute care facilities.)

At this time, we are not able to place a figure on the cost impacts. A detailed study is necessary. The need for additional acute or chronic beds in some areas, will be due to population increases. In other areas, the need for extended care beds may arise because there is no significant opportunity to reclassify or mothball "surplus" acute or chronic care beds. By "surplus" in this statement we make the assumption (with which not everyone would agree) that the beds occupied by "bed blockers" are not all required for patients who require the care for which the bed was originally designated.

6. So, what can be done?

It is simplistic to assume that all decisions can be made on a province-wide basis. The province is simply too big to deal with capital planning on a macro basis. An alternative would be to work with District Health Councils and solicit proposals for reclassification of acute, chronic or extended care beds with the intention that the capital funds required for the purpose would have a high priority. Indeed, such costs could well be financed, in part at least, from potential savings in operating costs.

Incentives could be provided to hospitals to use money saved to help develop alternative programs such as providing community care programs.

Among the advantages are:

- For providers – the flexibility to deal with growing demand areas;
- For funders – significant long-term avoidance of increases in capital costs;
- For consumers – an opportunity to obtain the appropriate type of care required.

7. Priorities for capital expenditures

Ontario's experience has demonstrated that demands for capital expenditures significantly outstrip the resources that have been made available. Clearly, a plan is required to ensure that the investment in physical facilities is maintained and that new or replacement facilities come on stream at the appropriate time. However, the significant changes taking place in the delivery of health care must also be recognized. The emphasis on non-institutional care and community and ambulatory programs will decrease the expenditures that otherwise would have to be made for inpatient facilities. However, expenditures will still be required on institutional facilities – the need cannot be ignored.

An appropriate level of capital expenditures for our health care system needs to be determined. This could be based on life-cycle estimates and possibly tied to a percentage of total health care expenditures.

The government clearly has responsibility to set the total of funds to be made available. Within the funding the government deems appropriate, we suggest that the Ministry should develop a list of priorities. A system of categorization should be introduced. As an example:

Category A:
- Correction of hazards (fire safety, etc);
- Compliance with legislative requirements.

Category B:
- Reduced operating costs;
- Projects with a pay-back;
- Self-financing project.

Category C:
- Investments to facilitate restructuring of facilities to make them appropriate for a lower level of care;
- Investments in ambulatory care;
- Investments in community care;
- Alternative delivery systems (e.g., Comprehensive Health Organizations).

Category D:
- New facilities to serve a growing population.

Category E:
- Other investments that will incur additional operating costs.

We suggest that the Ministry consider developing a system of categorization and of priorities for the capital funds it has available.

8. Look at alternative funding sources

Elsewhere in this report we have suggested that consideration be given to alternative sources of operating funds. This is also important for capital. Topics such as tax-free hospital bonds or creative use of the taxation system might be considered to encourage investors to help finance capital costs. However, in any such development, the Ministry must retain control over approving the investment since ongoing operating costs are so important. (We earlier noted that initial capital costs generally represent only about 2% of total life-cycle costs of a hospital facility.)

Capital funding regulations and cost-sharing arrangements should be harmonized, so that incentives are provided to achieve the overall goals of the health systems. Thus, we suggest higher levels of funding should go into areas the government wishes to emphasize, such as:

- Community care;
- Ambulatory care;
- Alternative care;
- Cost-saving projects.

Equally, the planning process used by the Ministry should be stream-lined, to avoid abortive expenditures on consulting and architectural fees for projects that may be

stalled for many years. And a system of guidelines, delineating the space and cost levels the Ministry will support for its share of funding, would greatly facilitate the equitable sharing of capital funds.

9. Consider the tendering of new programs

Future health care funds for new programs and capital development will be limited. The province must ensure that the new funds are used as effectively as possible. In many other jurisdictions, the government calls for tenders from qualified suppliers to purchase services. Now the Ministry of Health uses this method to allocate new nursing home beds. It is possible that all new programs could be tendered to qualified providers.

6. RESEARCH FUNDING

1. Introduction

The funding for health research in Ontario comes from many varied sources. These include private subscriptions, private foundations, the Medical Research Council and the Ministry of Health. Funds from the Ministry of Health are applied directly to research projects through the health resources development plan. The funding from this program was budgeted at about $11 million in 1987/88. In addition to this support, the Ministry provides funds through support for hospitals and universities. It is difficult to determine the total funding for research in Ontario.

2. Ontario spends 1% of its health care costs on research, the U.S. more than 2%

Estimates on research expenditure seem to range around 1% of the total health care expenditures in the province. This is consistent with other provinces across the country. However, expenditures in the United States appear to be approximately twice as much, around 2%.

Quite apart from the total amount of funding, the allocation of the funds within the health care sector needs scrutiny. Again, data in this area are not readily available. However, indications are that systemic research and pilot projects should receive additional funding.

3. The need for health care research

The health care system in Ontario will be faced with many serious choices in the foreseeable future. Our analysis demonstrates that increasing cost pressure and demands in the health care system are rapidly exceeding the province's financial capabilities in any realistic and predicted sense. In the future, policy formulation, decision-making and alternative program selection must be well researched with objective data. The health care industry, like many other in industries, has examples of new technology or new programs that save money. However, on implementation, the anticipated savings often disappear. In many cases, prior research and experiment would have enabled decision makers to evaluate the benefits before approving these additional investments.

4. What is the true cost of lithotripsy?

One example is the implementation of lithotripsy. This machine, using ultra-sound, is able to provide non-invasive destruction of kidney stones. Before this technology was available, all kidney stones that would not pass through the urinary tract required invasive surgical procedures. This meant two weeks' stay in hospital and an additional two-week recovery period. The new lithotripsy machine allows this procedure to be performed in day surgery, with return to normal work within one or two days. The cost savings to the system are obvious. The initial cost of the machine is easily covered by the

cost savings related to the prolonged hospital care. Equally, the quality of life for the patient is enhanced by avoidance of the invasive procedure and the subsequent recuperation period.

5. We do not know the true costs of community care

There are many other examples of new technology and programs that can improve the health of the public and also reduce costs. The overall impact of this technology and programs must be clearly researched before decisions are made on implementation. The second major area where further research is required is the cost-effectiveness of community care. As we stated previously, the level of institutionalization in Ontario is extremely high. This is particularly true when measured against the age distribution of our population. We are considerably younger than most other developed countries that have a universal health care system.

The development of community-based programs will reverse the trend toward institutionalization. It will provide for a better quality of life and possibly more cost-effective care. However, the implementation of new community-based programs often provide for additional support to those already in the community. There will also be some replacement of services to those who would have previously been in the institution but were discharged to the community. In addition, those receiving care in the community may avoid institutional care for a longer time, or spend a short period of time in institutions. Research is required into each of these aspects for all programs that are considered for community support. Clearly there is a social benefit in allowing people to live in their own homes for a longer period of time. We need to know the financial implications of this treatment modality before implementing new or larger community-based programs.

Funds for new programs are always limited. And competition is intense for new money. We therefore need to review the impact of the future programs, testing them on a pilot basis before they become general policy in the province. In our health care system it is much easier to begin a new program than to cancel an existing one. We must ensure that the implications of these new programs are thoroughly researched and understood before they are implemented.

In Ontario, we spend about 1% of our health care dollar on research. The orientation of this research is mainly toward the development of new clinical information and the application of this information for improved health care delivery. Limited funds are available for systemic research to assist in policy formulation. In the United States the money spent on health research is over 2% of the health care budget. This implies that Ontario should consider spending more on health research. The options available are to continue with the distribution of funds as they presently exist, or to reconsider the direction of more funds towards research on the operation of the health care system. A number of areas identified during this project require further research. These include:

- The cost impact of community care;
- The cost impact of new technology;
- The overall bed requirements of the province;
- The development of outcome measures for the system;
- The impact of different methods of funding on the quality of care;
- The development of education programs to enhance patient choice;
- The viability of prevention and promotion programs and the cost impact to society.

We must decide whether to provide more funding to health research and then decide where to place this funding.

H. CONSUMER CHOICE

An irony of public sector health systems is that while they attempt to provide universal access to the system for the consumer, the monopolistic provision of health restricts consumer choice. The Ontario health care system is based on a number of implicit assumptions, one of which is "either we all get it –or nobody does." Laudable as this philosophy may be, it is inherently restrictive.

The Ontario health system differs from many other publicly-funded health systems inasmuch as we have no alternative private health sector available to consumers. In the UK, for example, 10% of the population is covered by health insurance. In West Germany, people can opt out of the public sector insurance scheme on reaching certain income levels. The development of private medical sectors in socialized medical systems invariably has occurred as a result of consumer disatisfaction with the public sector provision of care –usually hospital care.

Many opponents of a private hospital sector argue that it would result in a two-tier system of health service to consumers. However, if we examine the differences between public and private health sectors in, say, the UK, it is doubtful if the benefits enjoyed by the second tier place the first tier at risk. The principal use of the private sector in the UK is for elective surgery. Subscribers to private health insurance plans are able to decide exactly when their surgery will take place rather than having to respond at a day's notice to the admitting office of the local public hospital. Critics of this so-called "queue jumping" argue that if the public sector had more resources, waiting lists would not exist. There is some merit in this argument. However, while data are not available, our experience suggests that many of the procedures carried out in the private sector have very short lists.

Private sector hospitals in the UK also tend to be more responsive to consumer needs. For example it is virtually impossible to receive, say, physiotherapy in a public hospital outside of office hours. Patients frequently have to take time off work for post-operative physiotherapy. A similar situation prevails for imaging, laboratory tests and consultations with specialists. The absence of an independent medical sector clearly prevents those with the ability to pay supplementary insurance (probably more than a third of the working population) the choice of alternative health care sources.

The Ontario health system further restricts consumer choice, since resources are allocated to providers rather than consumers. For example, many elderly patients who could remain at home, given appropriate support, have no choice over whether to spend money on expensive institutional care or home support. One option to increase consumer choice in this respect would be the voucher system – whereby, for example, the consumer could elect to buy home care help or spend the voucher on extended or residential care. Similarly, consumers seldom have the choice to die at home rather than in hospital unless palliative care programs have been established in their communities. The voucher system would provide the consumer the option of cashing the voucher for hospital care or home support.

Taxpayers are also faced with a no-choice option with regard to the amount of tax paid for health care except very indirectly through the ballot box. Taxpayers cannot, for example, opt for a deductible as in car insurance. An option might be a reduction in the level of taxation if the consumer paid the first $500 of hospital care.

The resource allocation process in Ontario is based upon "the professionals know best." Consumers have little choice in, for example, whether a birthing centre is available in their community or if a traditional obstetrical unit is

maintained. The absence of a direct market link between providers and consumers has required policy makers to have finely-tuned mechanisms if they are to respond to consumer preference.

I. PREVENTION/PROMOTION

At every juncture, we confront the necessity of making our health care system more oriented towards disease prevention and health promotion. However, what this means, and how we can accomplish it, remains unclear to many.

Disease prevention and health promotion have evolved into two distinct concepts.

1. What is disease prevention?

Disease prevention can be categorized into primary, secondary, or tertiary prevention.

The purpose of primary prevention is to prevent the occurrence of disease through the identification and modification of risk factors. Primary preventative health services encompass interventions such as immunization, counselling, and family planning.

The purpose of secondary prevention is to detect and treat disease early so that the patient is cured or the disease progression is slowed and/or complications prevented. Secondary preventive services include interventions such as screening programs.

Tertiary prevention is often seen as disease treatment and rehabilitation aimed at limiting disability or restoring functions. In this section we focus on primary and secondary prevention.

2. How do we orient our system towards disease prevention?

As our system is currently organized, primary and secondary prevention services are principally provided as a component of primary care medical practice. Public health also provides prevention oriented services.

A number of issues must be addressed. Even well-informed practitioners are uncertain about what constitutes preventive practice. More rigorous evaluation of preventive measures is needed – for efficacy, effectiveness and efficiency – with a view to determination of agreed-upon protocols.

Once there is good understanding and agreement as to desired prevention protocols, high risk groups need to be assured of access. Some of the groups at highest risk for ill health never or rarely access the system for primary care.

Mechanisms under which patients are rostered and providers reimbursed by capitation provide a sound structure for an orientation toward prevention. Computerized patient information systems can then facilitate an organized approach to identification of high risk groups. Capitation funding schemes also provide a framework in which other health care providers, whose services are not as costly as those of a physician, can become involved in implementing prevention protocols.

In our system, the community health centre (CHC) and health service organizations (HSO), along with the newly proposed comprehensive health organization (CHO) could seemingly all be used to implement a strong preventive service base.

Caution needs to be exercised, however. Health Maintenance Organizations (HMOs) in the United States have many of the same organizational features as our CHC and HSOs and the newly proposed Comprehensive Health Organization. While HMOs have every incentive to keep people well, there seems to be some doubt about the cost-effectiveness of disease prevention to an organization that is concerned with the bottom-line. Cost savings come more directly from reducing hospitalization rates and length of stay.

The literature suggests that HMOs have, in the event, done relatively little in disease prevention.

While rostering and capitation, supported by good computerized patient information systems, provide a framework that could enhance prevention activities, an additional thrust is required to ensure that a re-orientation toward prevention does in fact occur.

3. What is health promotion?

In the early days, health promotion was seen as something that promoted and encouraged people to have healthy lifestyles, which meant observing good nutrition and personal hygiene and being physically fit. In recent years, health promotion has come to be defined much more comprehensively. The World Health Organization definition is:

"Health promotion is the process of enabling people to increase control over, and to improve, their health. It represents a mediating strategy between people and their environment, synthesizing personal choice and social responsibility in health to create a healthier future."

Inequities in health and health opportunities are a major issue in health promotion. Despite the many advances of our health care system, people's health remains directly related to their economic status. One challenge we face is to reduce inequities in the health of low income groups.

4. How do we orient our system toward health?

Substantial provincial and federal work has been done to develop a framework for health promotion. In Ontario in 1987, two separate groups reported on health promotion. The Minister's advisory group on health promotion, chaired by Steve Podborski, published its recommendations in "Health Promotion Matters in Ontario." Among them were:

- Immediately increase Ministry funding for health promotion and disease prevention activity by one percent of the overall health care budget;
- Examine policies and programs in all Ministries to assess their health impact and make consequential changes;
- Demonstrate new clear examples of inter-ministerial cooperation by consulting with appropriate ministries in dealing with issues such as housing, physical activity and pollution;
- Communicate a new partnership for health promotion through the public health sector, private sector, and community agencies;
- Establish a mechanism for greater local autonomy in health funding and planning decisions;
- Expand the profile of the Minister of Health as a primary ambassador for a new approach to health promotion.

At the same time another group, The Panel on Health Goals for Ontario, was working to define health goals for the people of the province. In its report Health for all Ontario released in August 1987, the following seven goals were proposed:

- Achieve equity in health opportunities;
- Enable Ontarians to achieve their health potential;
- Increase the health expectancy of Ontarians;
- Provide environments that support health;
- Encourage behaviours that support health;
- Provide health services that support health;
- Establish public policy that supports health.

The federal Minister of National Health and Welfare released a document Achieving Health for All: A Framework for Health Promotion in November 1986. This report outlines a broad conceptual framework and strategies for moving forward.

In one way or another, all these reports provide a framework for the development of public policy that supports health. While all areas of government must be involved in establishing healthy public policy, Health should be the lead Ministry. It's a large role.

At Queen's Park, within the Ministry of Health, the challenge becomes to plan for "health" in the broadest sense, not just health care services. In the Spasoff Health Goals Report, the District Health Council was suggested as the mechanism through which the health-goal process would be implemented. Indeed, health must be planned close to home. If they can be reoriented to focus on "health," District Health Councils can provide a mechanism for reorienting our system. Health needs at the community level need to be systematically assessed, incorporating identification and targeting of high risk/high need groups.

The community health centre model has been developed to address the requirements of high need groups. In the 1970's, this tended to mean poor inner-city neighbourhoods. Increasingly, the community health centre model is being developed to meet the special needs of immigrants or other groups with special language and socio-cultural needs. The community health centre is also an excellent instrument of health advocacy for high-need groups. The CHCs provide a vehicle through which community workers, health promoters and health educators advocate on behalf of the community and involve the community in activities to improve its own well-being and health.

The CHO and HSO models could be effective implementers of health promotion strategies.

In terms of funding mechanisms, money is required to support the study of health needs. Subsequently, proposals need to be ranked according to their ability to address the needs of high-need and high-risk groups and hence improve health.

J. ALTERNATIVE SOURCES OF FUNDING

Much of this report has concentrated on the way to dispense funds within the health system to provide and maintain quality of service in a cost-effective manner. However, when these initatives are put in place there may still be a discrepancy between the demands for funds and the revenues available. In fact, some would argue that the citizens in Ontario are very happy with their health care system and will be willing to put additional funds in the system to maintain it at its present level. Nevertheless, setting aside these views, new approaches are needed to provide the most effective use of the dollars that are available. We believe alternative sources of revenue should be considered by the Premier's Council as a component of the funding and incentives study.

The attempt is to manage the growth and redistribute the funding in the most cost effective manner. Once this redistribution has been completed, we will be in a better position to determine whether more funding is required or whether a redistribution of the source of funds should be considered.

The major issues we have identified will require careful consideration. Implementation of change – and some of it will be structural change – will have to be managed carefully, over a period of time. These options include:

- Charge chronic co-payment to all chronic patients regardless of their present placement;
- Provide OHIP premium exemptions and drug benefits only to those who truly cannot afford to pay;
- Allow the controlled development of private hospital options, as in the United Kingdom, New Zealand and the United States;

- Directly charge consumers for specific "hotel" services (e.g. alternate-choice meals in hospitals);
- Require more responsibility at the local level for care costs;
- Develop a full-cost insurance system for health care coverage.

The following section of the report describes in more detail the revenues and implications of each of these options.

1. Chronic co-payment

At present, chronic co-payment is charged to patients in chronic care beds who are able to pay. A number of exemptions are available. First is an automatic three-month waiting period to ensure that the patient is, in fact, a chronic care patient and will not be discharged. This can be extended by a physician to six months if the rehabilitative capacity of the patient is in question. Also, patients who are in acute care beds but awaiting placement in chronic care are not charged the co-payment.

The three-month waiting period is not in effect until patient is in the chronic care bed. If the beds occupied by these patients were defined as temporary chronic care, a chronic co-payment charge could be levied. Additional benefits of this could amount to $20 to 40 million per year.

In essence, the change would see the co-payment being levied on the basis of the patient's condition and needs, not on the bed he/she occupies, as is the case now.

2. OHIP premium exemptions and drug benefits

The Ontario government does not require the payment of OHIP premiums to those who cannot afford it, to those over 65 years and to the dependents of those over 65 years. The cost of the exemption to individuals over 65 and their dependents is approximately $600 million. If some individuals were able to pay the premiums there would be additional funds in the health care system. Similarly the drug benefit program provides free prescription drugs to senior citizens and welfare recipients. The cost of this program is about $540 million. With the majority of benefits provided to the 65+ group. Again, if some were able to pay, this would result in additional revenue for the system.

It may be difficult to implement these changes in view of the difficulty of providing means tests and the elimination of an existing benefit. If this is the case, the Council should consider the feasibility of making the deferrals and drug benefits a taxable benefit. Therefore, the change would not be nearly as dramatic and would ensure that only those able to pay were charged. An agreement with the federal government would be required for transfer of the funds to the province.

3. Motor vehicle accidents

Originally, the provincial health care system was not designed to support the cost of individuals injured in motor vehicle accidents. Private insurance of the driver at fault was to cover this cost. There were a number of problems, including uninsured drivers, which led to the provision of these services through the provincial plan. However, there is a direct cause-and-effect relationship between the injuries and the cost. If the individual insured were from out of the country, the insurance would pay for the medical costs associated with the accident.

4. Private hospitals

In three of the countries surveyed, a private hospital is available for people who are willing to pay or for people who have appropriate insurance. For example, about 10% of the UK population is covered by supplementary private health insurance. The private hospitals concentrate on elective surgery with improved convenience to their patients. The use of private hospitals obviously reduces the demand for care in the National Health Service hospitals.

Development of private hospitals in Ontario may not be consistent with the Canada Health Act. There are also political obstacles. For example, many would argue that this would introduce a two-tier health care system. People who were able to pay would be provided with better service than those who used the existing publicly-financed hospital system. On the other hand, the controlled development of a private hospital sector would definitely reduce the demands on the provincial government for funding and also introduce some comparative information. We would not suggest the uncontrolled development of private hospitals. Some form of licensing would have to be instituted. Indeed, if some form of regional structure or comprehensive health organization type of system were introduced, the private hospital sector could presumably be controlled and licensed through the regional organization, thus introducing some level of choice and of control over program development.

5. User fees

User fees are in conflict with the Canada Health Act. The argument in favour of user fees is that they are a deterrent to those who are abusing the health care system and would tend to reduce demand as well as generate additional income. Literature suggests (as indicated in Chapter V of our report) that a 10% cost levy for the health care system would reduce demand by less than 1%. This reduced demand would be felt particularly by the elderly and the very young. Indications are that those who require service would not receive it. An alternative is the voucher system or tax credit system for individuals who do not make use of the health care system. Again, we have the same danger of denying the health services to those who are in particular need.

Many user fees are, however, already in place in hospitals. For example, charges for T.V., preferred accommodation, etc. These could be extended to cover such items as an alternative choice of meal to the "standard" meal provided by the hospital.

6. Local taxation

In Sweden, the major cost of the health care system is covered by a tax levy at the local level. In this way, communities can decide what level of health care programs they want in their area. They would then levy the taxation to support these programs. This level of taxation would be particularly advantageous in connection with the development of local health authorities. At the present time, the capital redevelopment of our hospitals is provided through a shared-funding mechanism. Partial payment (1/3 in southern Ontario and 1/6 in northern Ontario) is provided by local support. The remainder is covered by provincial grant. Therefore the concept of local support to health care development now exists in Ontario. Increasing the local participation could introduce some additional funding to the system and provide funding specific to the needs and desires of the local community.

7. Full-cost insurance

In the United States and West Germany the insurance programs typically cover the full cost of the health care services. There is little government participation for those who can afford to pay. In West Germany the insurance coverage is provided by the employer. This method provides a very effective lobby to control the health care costs.

8. Conclusion

The above section describes additional sources of funds that in some cases can provide alternative funding for the health care system. Inevitably, the cost of the system must be matched with the revenues available. We have suggested a number of initiatives throughout this report where incentives can be developed for providing cost-effective care. Some of these initiatives will require additional seed money and in the

long run should provide the balance between the available revenues and the cost. If not, additional revenues will be required from the Ontario government. The government may also wish to adjust the dependencies of revenues bases. This could involve a number of initiatives listed above.

K. COMMUNITY-BASED PROGRAMS

Throughout this report we have indicated the need to review and adjust the institutional basis of our health care system. We are a relatively young population with an extremely high rate of institutionalized health care.

The amount of funding from the Ministry of Health allocated specifically to community care is a very small percentage of the overall health care budget (about 4-5%.) However this is certainly not the full extent of community-based programs. A large percentage of the practice time of Ontario physicians is devoted to treatment of ambulatory patients. Hospitals have been moving from an inpatient focus towards ambulatory care. During 1986-87, for every patient admitted to the hospital, nine patients were seen on an ambulatory basis. For every patient that was admitted for a surgical procedure approximately one surgical patient was cared for on a day-care basis. Many hospitals are now developing programs that support patients on a community base. Therefore the community-based activities within the health care sector are, in reality, far greater than the 4-5% of funding reported in the Ministry of Health budget.

In this report we have discussed the needs for incentives to provide additional support for community-based care. Under our description of organization and linkages in this chapter we discussed the integration of community-based and institutionally-based care. We indicated that, through the changes in our organizational framework, additional initiatives for moving from inpatient to ambulatory and community-based care will be possible. In our discussion of the funding system for both hospitals and physicians, we described the need for incentives to provide more care on an outpatient and community basis. We indicated the need for research funds to provide further evaluation on the overall impact of shifting towards more community-based care. Clearly, a direction for the future is to provide incentives to move more towards a community-based care network within our health system. It may be necessary to identify specific envelopes of funds that would be directed to community-based programs.

Simultaneously with the conduct of this study, another consulting firm is reviewing the future requirements of community-based care. The direction suggested in that report could be reviewed against the funding initiatives to ensure that adequate funding and incentives will be available to move the system in the directions identified with that study.

SUMMARY

The previous chapter has provided an analysis for the reader of a number of alternatives for funding the Ontario system. We must always keep in mind in the review of these alternatives that the major objective of the health system in to create an environment for all citizens to maintain their overall health.

We have described a number of alternatives and options available to the Premier's Council to effect change in the health care system. We have suggested that the changes should be considered in the light of equity, quality and cost-effectiveness. These are the goals that we believe must certainly be maintained and, where possible, improved on in the short-and long-term future. Adjustments to the funding system must move the province toward these goals. In the following chapter, we describe how, within the overall range of options and alternatives, the Premier's Council should select those which achieve these objectives.

CHAPTER VIII
CONCLUSIONS

Changes to the health care system can be facilitated by two major tools. The first tool is through changes in legislation or regulations. In this way providers and consumers can be mandated to perform in a certain way. The preferred tool is to adjust funding and incentives to move the system in the appropriate direction. This report deals with changes through this mechanism.

The preceding chapters of this report provided detailed discussion on the operation of the present Ontario health funding systems. We identified those areas that are working effectively and those areas that require some modification. When we reviewed the areas that require modification, we recognized that some issues could be solved directly by enhancement or changes in the funding and incentive systems in the province. Other issues and problems required overall systematic changes. However, many of these could be facilitated by changes in the funding and incentive practices.

In Chapter VII we provided detailed descriptions of the options and alternatives that are available to the province. These alternatives have long-term impacts. In order to help the sub-committee analyze these alternatives, a retreat was held with a very experienced group of advisers with local, national and international expertise. A list of the attendees is included in Appendix B. Over a two-and-a-half day period this expert panel provided input to the health care system sub-committee on issues relating to the community study and this funding and incentive study.

In order to facilitate the discussion surrounding the funding and incentive study we identified four major groupings. The expert panel was divided into four working groups, with each working group discussing one of the topic areas. The topics were:

- Organization and linkages;
- Hospital funding systems;
- The role of the individual and alternative sources of funding;
- Physician funding systems.

Each of the groups spent considerable time discussing the individual topic. In a plenary session, each reported the results of the discussion to the entire expert panel. At that time, other members of the expert panel provided additional input to the topic area. This chapter summarizes the discussion and recommendations presented by these groups.

1. Organization and linkages

Our previous chapters highlighted the need to consider not only funding and incentives to move Ontario's system closer to its goals, but also to consider the organization and linkages of the current system. The expert panel evaluated the issues raised in our report on the current organizational framework for health and health care in Ontario and made recommendations on a number of initiatives to overcome weaknesses.

The expert panel reached a reasonable degree of consensus on the following issues:

- Given the large number of hospitals, agencies and other providers with direct links to government, service integration and resource allocation are centralized functions that should be delegated to the "local" level. The government should focus on strategic issues and distance itself from operational matters. At the same time, consumer involvement in resource allocation should be increased;
- It was acknowledged that in comparison with many other jurisdictions, the Canadian health system was expensive in both absolute and relative terms. Use of the system, for example bed days per 1,000 population, is higher than in many other jurisdictions. There was consensus that the cost of the system could be reduced by rationalization and improved utilization without compromising quality or access to care;

- Given agreement on the potential for reducing costs or reallocating resources to other programs, the question was posed – "Why haven't these economies been realized?" A number of reasons were articulated. First, there is no effective change agent within the system at the local level. District Health Councils had made some inroads into program rationalization. However, in view of the number of independent players in the system, the success of DHCs has been limited;
- A further reason is the "tenure mentality" – or once a program is in place, it should always be in place. To a large extent, provider self-interest perpetuates the status quo. In addition, competition among providers, particularly hospitals, drives the system to be bigger and more expensive;
- The multiplicity of independent providers presents problems not only to "rationalizers", but also consumers. Linkages between various elements of the health care system (organized and funded differently) have to be provided by consumers. Consumer access could be improved by information systems and professional assistance. However, many barriers were seen to be organizational;
- It was also thought that integration and rationalization might be hampered by the different service boundaries of hospitals, community services, municipalities, schools etc. A long-term strategy to uniformly improve organizational boundaries for the delivery of health and social services would assist service integration.

The expert panel was asked to consider a number of organizational options to decentralize the decision making process in the health system. These included:

- Strengthening the role of District Health Councils;
- Expanding the role of hospitals to include community services;
- Establishing comprehensive health organizations;
- Establishing local health agencies.

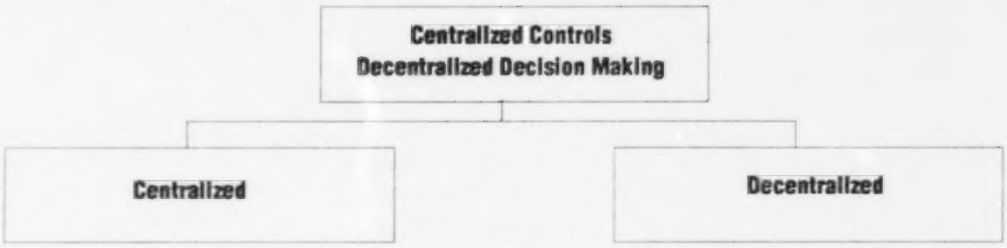
The consensus was that flexibility was the wave of the future, rather than a uniform approach. A number of test models were recommended to be carried out concurrently. It was agreed that rate of change in the system in terms of devolution of decision making to the local level must be reasonable and not overburden organizations.

It was also thought that rationalization required a top-down approach not bottom-up. The governance of organizations is an essential issue in the facilitation of change. Unless boards are committed to realize the benefits of rationalized services, barriers to change will be unsurmountable. But there will be resistance to change. Providers naturally "protect their turf." Implementation will require a balance between consensus and force, and the community must agree to the change.

The expert panel also considered the role of the private sector in providing care. Despite philosophical differences that may exist, it was felt that there was a role for the private sector to play. How this role is developed will depend on a variety of factors, not the least of which is the will to accept a specific role or roles that the private sector can play.

The general direction that a decentralized system should take is illustrated in Exhibit VIII-1.

EXHIBIT VIII-1



Centralized	Decentralized
Long-term strategy	Decision making on resource allocation
Planning	
Structural framework	Incentives for rationalization and utilization (create the best health care outcome within the resources available)
Standard setting	

In essence, the provincial government must maintain controls over standards and set the long-term strategy for the system. Local and larger units of management will still be required to plan. However, they will also be able to allocate resources according to their own priorities and the needs of their communities.

2. Hospital funding

In the discussion of hospital funding at the planning retreat, people agreed that it was important to confirm guidelines that would form the basis for the discussion. In general terms, our hospital funding system is now working reasonably well. It is relatively simple to manage. It provides effective cost control. The growth of costs in the hospital sector has been relatively consistent with the growth of provincial product. It was also noted that problems and issues confronting Ontario hospital funding are similar to those in many other countries. Most jurisdictions are looking to change. No comprehensive solution can be found in another jurisdiction.

a) The group confirmed the issues and problems presented in this report

The following list of issues and problems was discussed and agreed to by the expert panel:

- Since the introduction of global budgeting in 1969, hospital expenditures have remained relatively stable in real dollar terms as a percentage of gross provincial product;
- Hospitals consume the largest component of the MOH budget, over $5 billion in 1987/88;
- Most health care sectors offer no direct reward for improved effectiveness or efficiency in health care delivery;
- The conjoint study of hospital operational reviews identified a lack of understanding and consistency in applying the hospital funding system;
- The lack of clearly-defined outputs from the health care system makes it difficult to assess the relationship between outputs and expenditures;
- The pressure for cost control does not reach the grass roots level of the health

care system where costs are incurred. Within the hospital system, institutional forces motivate higher expenditures;
- There is a strong perception that the funding of hospitals is not equitable from one institution to another;
- The capital development requirements, as they have been identified, far exceed the province's ability to pay;
- Based on many accommodation studies, our health care system does not succeed in placing people in the correct level of accommodation as often as might be desired. Suggestions are that 10% of acute care beds and 25% of chronic beds are occupied by patients who should be elsewhere.

b) Other concerns were raised

The expert panel provided additional insight into the problems confronting the Ontario system. They were as follows:

- The present system for funding hospital growth provides an incentive to increase outpatient and day care by hospitals, but no direct incentive to reduce inpatient services;
- A fee-for-service system was recognized as encouraging additional activity that is not necessarily reflected in increased productivity (in terms of outcome to the patient);
- Some panelists were concerned that the range of revenues produced by hospitals under the BOND program could be curtailed as a result of a review by the Public Trustee;
- The solution to hospital funding must be in harmony with the payment of physicians and other providers the health care system.

c) What are the alternatives?

i) Operational funding

The present global budgeting system is relatively easy to manage and provides control of costs in the overall hospital system. However, hospitals argue that significant inequity has developed in the funding of various hospitals. Methods of funding hospitals and funding physicians are not compatible. We need to develop incentives that promote movement away from the present concentration in favour of institutional care.

Within the industry a number of alternative payment systems are available for hospitals:

An itemized payment of service

Under this system hospitals are reimbursed for each and every service provided. This system tends to be administratively complex and does not provide effective cost control. However, it does provide detailed information on services provided to the patient.

The expert panel recognized the value of the additional data. However, because the system is open-ended with no cost control, it would not be workable in Ontario. Also, it would cost more to operate. Therefore, it should not be considered.

Daily charges

Under this system, hospitals are reimbursed for each day of care given to patients in the hospital. The system is somewhat simpler than itemized service payments, since it does not require a detailed information bank on services provided to patients. This system provides incentives for controlling per diem rates. However, no inherent incentives exist to improve utilization control and reduce length of stay.

The expert panel noted that the incentive within the system is to increase utilization. There would be some value in daily charges if effective incentives could be installed. Per diem rates would

have to be adjusted for changes in case mix. The committee felt that daily charges could not be used for the entire system but might be useful for some specific areas, for example long-term care.

Case payment

Under this system, hospitals are reimbursed for each admission. The admissions are weighted by case complexity. This system provides direct incentives to control both per diem costs and utilization for patients admitted to the hospital. However, there is little control on the level of hospitalization of patients. Case payment does not cap total expenditure.

The panel noted (based on discussions between the OHA and the MOH) that we are currently heading in this direction. The interim funding system is likely to contain case-mix options within it. The panel noted that this was the system that could best deal with the actual hospital costs and provide built-in incentives. Also, within a case-mix system, it is important to maintain global budgeting.

Initially, the case-mix payment should deal with the year-to-year budget increments. However, in the long term it should be the basis for the entire global budget. In this way, the problem of inequity could be solved.

Controls must be installed within the case-payment system to preclude incentives for unnecessary increases in volume. The panel noted that within the case-mix system the ambulatory-care component is not well handled; a new system would have to be developed. Also, experience in the United States demonstrates the need to control "DRG creep" (The level of intensity of patients should result from increased acuity not just better reporting).

The panel also noted that the case-mix system must have a global cap. An open ended system based strictly on volume of case mix would not be acceptable to the government.

Capitation

Under this system, the hospital is prepaid a capitation rate for each resident within a service area. This system has incentives for controlling costs, utilization, and hospital admission rates. It may, however, restrict consumer access to service. The administration of a capitated system might require linkages with HSOs or CHOs to be effective.

The panel concluded that capitation would be difficult for hospitals to implement. Research is needed before any decision on implementation. The panel agreed that it could be very useful for regional allocations. However, it was not supported for individual hospital funding.

Program funding

The expert panel discussed the concept of program funding. This is the process through which the Ministry of Health funds new program developments in hospitals. The panel felt that program funding is appropriate for new programs until they are operating at a steady state. Therefore, the funding of hospitals should include a component for program funding.

Other suggestions from the panel

The panel strongly recommended that the system create incentives that are co-ordinated between doctors and hospitals. There was general support that more funding was required in the community. Hospitals, given the proper incentives, could develop these programs. In the UK, hospitals were given a target to transfer a percentage of their operating funds to operate community-based programs. It was thought that this would be a more effective method of developing community programs than attempting to remove funds from hospital budgets and put them in other agencies.

ii) Capital funding

In the overall life cycle of a hospital, capital construction costs may represent only 2% of the overall health care costs. In other words, the operating costs associated with the redevelopment of capital are very significant.

In 1986, the Ontario government committed $850 million for the development of 3600 additional beds. We understand that the estimated costs of these commitments have escalated to perhaps double the original estimate. At the same time, developments have taken place in the health care field that increase the emphasis on ambulatory and community-based programs, reducing the need for institutional care.

Many accommodation studies indicate that approximately 10% of acute care beds and 25% of chronic care beds are occupied by patients who should be placed elsewhere. Many patients are placed inappropriately in high-cost facilities. Their true needs are for less intensive care. In the United States, the dependency on acute care beds is approximately 25% lower than in Ontario.

The plans to add additional acute and chronic beds to the system should be delayed until such time as the true bed needs of the province are established. There could be significant cost savings as the operating and capital costs for extended care beds are signficantly lower than for chronic or acute care facilities.

However, some capital investments cannot be postponed. Developments that ensure fire codes are met, and potential future hazards are avoided, must continue. Also, capital developments that can reduce operating costs should be considered immediately. A priority system for capital investment should be developed to assist in the approval of capital expenditures.

Comments from the expert panel

The expert panel commented on the present improved capital expansion and suggested that capital plans should not add beds until the new direction of the health care system is clearly established. Adding 4,000 new beds is entirely inconsistent with the present health care directions. A major review is required. There was a strong recognition that capital additions to the system can drive up the operating costs. This should be fully recognized before additional capital expenditures are incurred.

There was a suggestion that as we modernize and develop more community-based thrusts, the provincial bed stock might be reduced.

The panel also recommended that a review of the guidelines for hospital space and construction costs be commissioned. Substantial savings might be attained by more modest capital construction guidelines.

d) Summary

In summary, the expert panel recommended a movement towards case mix funding for hospital operating budgets. Within this case mix funding the global budgeting system should be maintained. The funding of physicians and hospitals needs to coordinated to ensure that provincial goals are attainable at both levels. There may be specific uses within the health care system for per diem rates (for example long-term care institutions) or program funding, for example for new programs.

The expert panel recommended that the present plans for adding 4,000 beds to the bed stock in Ontario be postponed pending a complete review of the current trends in the health care system. There was a general feeling that the movement towards community-based care could provide for a reduced bed stock in the province. Also, the guidelines for new capital construction should be reviewed to ensure that the future developments are cost effective and that we move towards a more modest hospital facility program.

3. Role of the individual

The work of the Premier's Council in Alberta was introduced and discussed briefly. It was reported that one of the tasks given to that Council was to interview the residents of Alberta. From those interviews two conclusions were made:

- Residents wanted a participating role;
- Residents were willing to pay extra for some health care services.

The group generally accepted the fact that priority setting must be achieved and this could be accomplished by a joint process between consumers and providers. There was concern that the consumer had no real ability to say "No."

Further discussion on the prevention/promotion issues for individuals centered around whether or not there should be a separate and distinct fee schedule related to this area so as to encourage physicians to be involved with this aspect of health care. No specific conclusions were drawn from this discussion.

Finally, related to the role of the individual, a statement was made that there should be a fairer distribution of funds within the Province. That the funding system should be used to shape the health system of the future.

4. Alternative sources of funds

It was agreed that the Canada Health Act mandates a generally accepted philosophy in Canada, and that any attempt to change universal accessibility to the system or create a double standard system was not acceptable.

The issue of OHIP premiums was discussed. Some members of the panel supported the discontinuance of OHIP premiums.

There was not support for the development of a full cost insurance system. There was considerable debate related to the taxable benefit of OHIP premiums for those people over the age of 65 who have substantial means. Discussion centered around the fact that many individuals over the age of 65 paid taxes that contributed to financing health care. There was a definite feeling that any means test in health must be avoided, since this would be contrary to the underlying philosophical doctrine of the Canadian system.

A short discussion centered around the development of a private health sector. There were concerns that this would create a double system as in United States. Certain aspects of privatization were supported. However, there was concern that there would not be an equal interface with the private and public system thus leading to the situation

where the private system would have the cream and the public system would serve the difficult cases.

There was concern that the drug benefits program encouraged the use of medications and was not health or cost effective. Many individual cases of polipharmacy were cited.

The voucher system was supported with some enthusiasm. The details of the voucher system were not be discussed fully, however, there was support for the possible options that it could create particularly for the disabled and elderly.

No statement was made related to user fees for hotel services. The general concept of user fees was rejected as being contrary to the philosophy of the present Canadian system.

5. Physician funding systems

The working group dealing with physician payment systems agreed that there were basically only three fundamental ways of paying for physician services namely:

- Fee for service;
- Capitation;
- Salary.

Clearly there can be modifications of the various basic payment mechanisms. For example the fee for service system could be modified to introduce capping at certain levels or it could introduce different weights in order to induce physicians to move to under serviced areas (geographic weighting). Equally, it could be weighted to emphasize the physician's experience; and it could be weighted to encourage services such as health promotion.

The advantages and disadvantages of the various systems were fully discussed. In general, the working group concluded that a mixed remuneration system would best meet the future needs of the province, the providers, and the residents of Ontario.

However, the working group also recognized that the system could not be open-ended. Controls are required.

At the same time the overall financial limitations on the system should recognize the need to meet social and health goals and also provide fair remuneration for those working within the system.

From the government's perspective the payment system used would have to be consistent with overall provincial and regional policies. It would also have to respond to the needs of the population and ensure a high level of quality.

From the provider's viewpoint, the physician payment system should ideally recognize the physician's expertise and productivity. Some allowance for the physician's experience might also be considered.

The working group also discussed the need for a dispute resolution mechanism. This issue has some visibility because of the recent fee negotiations between the government and the Ontario Medical Association. However, in looking at this matter the working group felt that we should ideally be looking to the future and not become embroiled in recent events.

While recognizing that the government has the overall constitutional right to levy taxes and determine payments, nevertheless the working group felt that some form of binding arbitration might be considered for the future.

6. The panel's views

i) The government must be capable of limiting the payments that will be made from the provincial purse for physician services. Equally, the funds available must ensure the provision of high quality care to the residents of Ontario and also fair remuneration for the physicians.

ii) A mixed reimbursement system should be encouraged. The flexibility afforded by such a system is invaluable. It can allow for different payment systems that meet the specific needs of physicians and of patients. A fundamental principle is that "choice" on the part of physicians and patients is important.

A mixed reimbursement system can be used creatively to meet specific needs. For example, the fee for service system could be weighted to encourage the provision of health counselling. It could also be used to induce physicians to locate in under-serviced areas.

With regard to capitation systems the Ministry of Health might consider negotiating individual rates, perhaps on a geographic or other basis, rather than having a universal rate laid down by the government. The strength of a capitation system is that it effectively caps or limits the total payments that will be made in any financial period. However, it does not encourage productivity. Thus, some flexibility should be encouraged in developing a capitation based system. The final payment system is by salary. This is already acceptable to some physicians and an "envelope", including salary and other elements might well be an attractive way of proceeding. An example could be a bonus system for added work including on call duty and other additional services.

Flexibility is the key.

iii) For the future we need to develop an effective and acceptable dispute resolution mechanism.

iv) Whatever physician funding system is used it must provide adequate and fair remuneration for physicians.

v) The physician funding system must be responsive to the public's social and health goals.

Exhibit VIII-2 summarizes the conclusions and provides a recommended implementation time schedule. The first column lists activities that should take place in the next year. The second column shows activities for the next five years. The final column lists activities for the next five year period – ie. 1995 to the year 2000.

EXHIBIT III-2

TOWARDS THE YEAR 2000

RECOMMENDATIONS

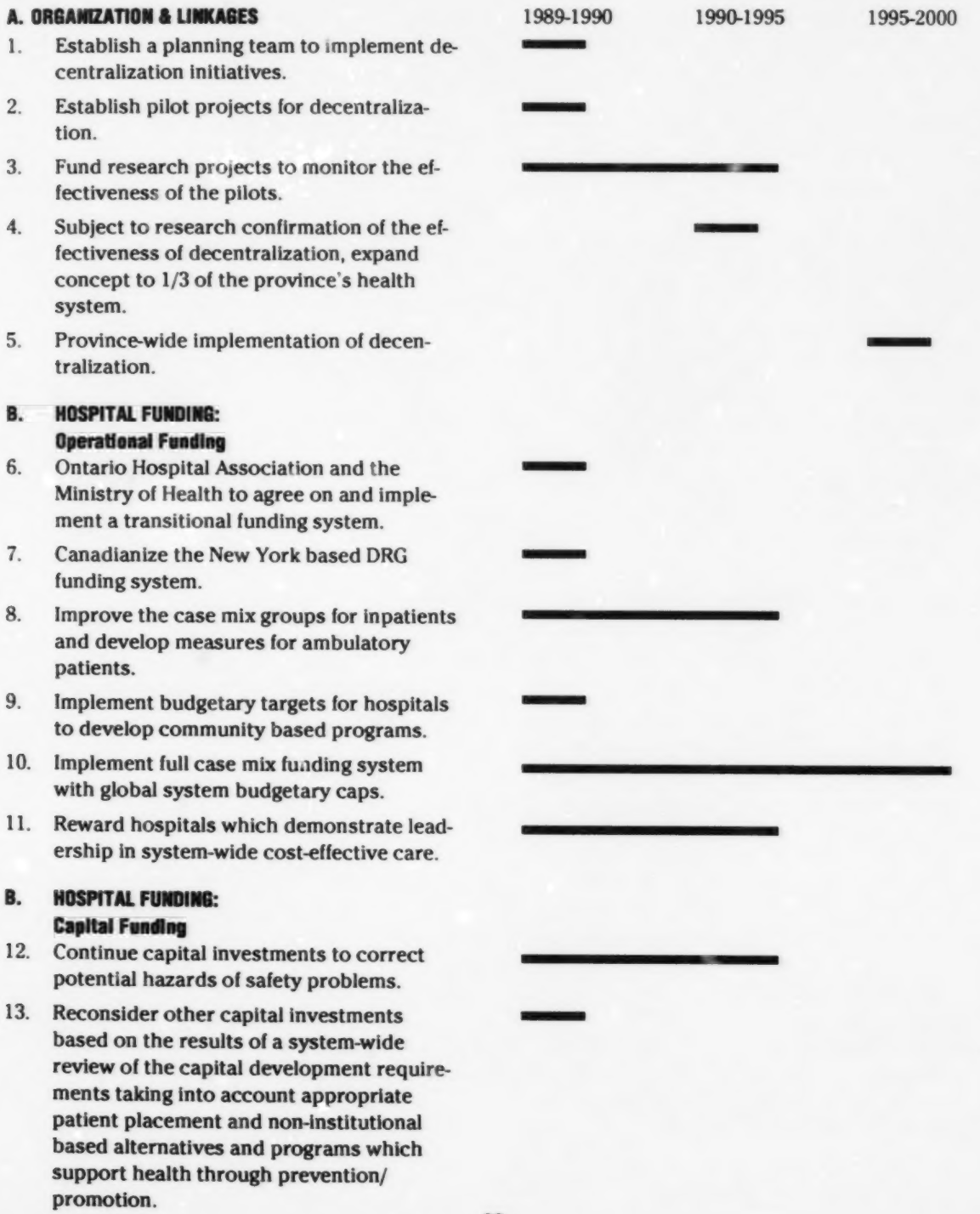

A. ORGANIZATION & LINKAGES
1989-1990
1990-1995
1995-2000
1. Establish a planning team to implement decentralization initiatives.
2. Establish pilot projects for decentralization.
3. Fund research projects to monitor the effectiveness of the pilots.
4. Subject to research confirmation of the effectiveness of decentralization, expand concept to 1/3 of the province's health system.
5. Province-wide implementation of decentralization.
B. HOSPITAL FUNDING:
Operational Funding
6. Ontario Hospital Association and the Ministry of Health to agree on and implement a transitional funding system.
7. Canadianize the New York based DRG funding system.
8. Improve the case mix groups for inpatients and develop measures for ambulatory patients.
9. Implement budgetary targets for hospitals to develop community based programs.
10. Implement full case mix funding system with global system budgetary caps.
11. Reward hospitals which demonstrate leadership in system-wide cost-effective care.
B. HOSPITAL FUNDING:
Capital Funding
12. Continue capital investments to correct potential hazards of safety problems.
13. Reconsider other capital investments based on the results of a system-wide review of the capital development requirements taking into account appropriate patient placement and non-institutional based alternatives and programs which support health through prevention/ promotion.

EXHIBIT III-2

	1989-1990	1990-1995	1995-2000
14. Provide capital funds for projects which are self funding or provided future operating savings which will cover the capital costs.	———	———	———
15. Provide capital funding to modernize the health care system within the framework of the future system requirements.		———	———
C. PHYSICIAN PAYMENT SYSTEMS			
16. Allow the development of a mixed reimbursement system for physicians. All mechanisms should provide incentives for positive health outcomes and provide a fair compensation level for physicians.			
17. Modify fee for service payment to recognize factors such as experience, health counselling, geographic needs, etc.	———		
18. Modify fee for service payment to include incentives for cost-effective care, reduced institutionalization and enhanced prevention/promotion.	———		
19. Review capitation payments to reflect regional needs.	———		
20. Develop a salary and incentive bonus system.	———		
21. Establish a 'cap' (e.g. a weighted population base) on medical payments from OHIP.	———	———	
22. Develop dispute resolution mechanism.	———		
D. ALTERNATIVE SOURCES OF FUNDS			
This report has concentrated mainly on methods to effectively manage the growth and distibute the current funding in the most cost effective manner. Once this redistribution has been completed, we will be in a better position to determine whether more funding or whether a change in the sources of funding is required. In assessing these issues Council should consider the following options.			

EXHIBIT III-2

	1989-1990	1990-1995	1995-2000
23. Consider the following options as alternative sources of funds. • Introduce co-payment for hotel services in acute hospitals. • Establish pilot health care voucher system for Ontario residents. • Charge chronic co-payments to all chronic patients. • Introduce a tax allowance for those consumers opting for a health insurance deductible of $1,000 per year. • Eliminate OHIP premium exemptions or drug benefits to the over 65's who can afford it or include the OHIP deferrals and drug benefits as taxable income. • Introduce a full cost health tax, collected by employers, with a corresponding reduction in other taxes.	———	———	
24. Introduce selected alternative funding sources.		———	
E. OTHER			
25. Double current expenditure on research. Give priority to health system delivery research projects (e.g. the cost/benefit of community vs. institutional care).	———		

APPENDIX A

ASSUMPTIONS FOR HEALTH CARE EXPENDITURE PROJECTIONS

- Population projections for Ontario are based on: Statistics Canada, *Estimated Population by Sex and Age Group, Canada, Provinces and Territories 1986-2011* (Ottawa, 1988) Projection 3: Medium Fertility, High Immigration and Significant Westward Migration.

- Labour force dependency rate based on 20 to 64 age group and labour force participation rates as follows:

Age Group	*Male*	*Female*
20-24	86%	77%
25-44	96%	73%
45-64	86%	51%

Source: Ontario Statistics, 1984

- Utilization rates
  a) Hospital patient days per 1,000 population: constant at 1,203.6.
  b) OHIP claims per insured resident: increasing at 4.0% per annum.

Source:
  a) Ontario Ministry of Health, *Hospital Statistics*.
  b) Ontario Ministry of Health, *OHIP Practitioner Care Statistics*.

- Cost per unit rate of change (constant 1984 dollars – using CPI adjustment):
  a) Ministry of Health cost of "Institutional Health" (excluding nursing homes and special warrants) per hospital patient day: increasing at 2.2% per annum.
  b) Ministry of Health cost of "Health Insurance" per OHIP claim: increasing at 2.0% per annum.
  c) Other Ministry of Health costs (including nursing homes and special warrants) held at constant percentage (1988/89 estimates) of total Ministry of Health "Institutional Health" (excluding nursing homes and special warrants) and "Health Insurance" costs.

APPENDIX B

LIST OF ATTENDEES

Mr. Roy Aitken
Chair, Health Care System Committee
Premier's Council on Health Strategy

Mr. John Carter
Member, Health Care System Committee
Premier's Council on Health Strategy

Ms. Eleanor Ross
Member, Health Care System Committee
Premier's Council on Health Strategy

Dr. Hugh Scully
Member, Health Care System Committee
Premier's Council on Health Strategy

Dr. Martin Barkin
Deputy Minister of Health
Secretary, Premier's Council on Health Strategy

Ms. Marilyn Knox
Executive Director
Premier's Council on Health Strategy

Mr. Mike McEwen
Ministry Liaison
Health Care System Committee

Mr. Lorne Zon
Manager, Health Innovations
Premier's Council on Health Strategy

Ms. Terry Bisset
Manager, Internal Relations
Premier's Council on Health Strategy

Mr. Graham Scott
Chairman
Task Force on the Use and Provision of Medical Services

Dr. Reva Gerstein, O.C.
Chair, Healthy Public Policy Committee
Premier's Council on Health Strategy

Ms. Mary Shamley
Chair, Health Goals Committee
Premier's Council on Health Strategy

Dr. Naomi Rae-Grant
Member, Integration & Coordination Committee
Premier's Council on Health Strategy

Dr. Robert MacMillan
Assistant Deputy Minister
Community Health
Ministry of Health

Dr. Jim Shosenberg
Manager, External Relations/Communications
Premier's Council on Health Strategy

Mr. Jay Kaufman
Assistant Deputy Minister
Institutional Services
Ministry of Health

Ms. Jennifer Ritchie
Consumer
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COMMUNITY SERVICES STUDY

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March 15, 1989

Mr. Roy Aitken, Chairman
Health Care System Subcommittee
Premier's Council on Health Strategy
56 Wellesley Street West
Toronto, Ontario
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Dear Mr. Aitken:

Price Waterhouse is pleased to submit its Report on the Community Services Study carried out for your committee of the Premier's Council on Health Strategy. Neil Stuart and Deborah Leach, the two consultants primarily responsible for this study, would particularly like to thank the committee members and Council staff for their thoughtful support and advice through the study period.

We look forward to further opportunities to assist the Council.

Yours very truly

Robert D. Bromley
Partner

RDB/sd

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EXECUTIVE SUMMARY

Much attention has been given to the importance of strengthening community services in the Ontario health care system. A succession of reports over the last few decades has contained recommendations to enhance the role of services provided in the community. However, many of these recommendations have not yet been translated into action.

The Health Care System Subcommittee of the Premier's Council on Health Strategy commissioned this study with a view to identifying strategies to achieve progress toward a stronger community services sector. It was the view of the Committee that the principle challenge is not so much to develop new proposals for delivering community services but to understand why past recommendations have not been implemented and to identify strategies to ensure whole-hearted implementation of such recommendations for the future. This study, therefore, set out to accomplish the following:

- review previous recommendations for enhancing community services;
- examine issues and problems that contribute to the rationale for community services;
- develop a vision for community services;
- identify obstacles to achieving the vision;
- identify positive factors that could be harnessed to help achieve the vision;
- recommend initiatives;
- provide an implementation framework.

In conducting this study, the consultants interviewed many spokespersons and commentators on health care in the province, prepared a preliminary discussion paper and held an expert panel conference to review the discussion paper.

Definition of Community Services

For this study, we adopted a definition of community services that sees community services as services that are defined primarily in terms of their focus, locale, accountability and who provides the services:

- the *focus* is on individual independence, local health needs, and the achievement of direct impacts on health;
- the *locale* for the provision of services is the home or the local community;
- *accountability* for planning, management and results for the services lies with the local community and those who provide the services;
- the *providers* of services include professionals, non-professionals and volunteers.

Rationale

We reviewed the rationale for emphasizing community services offered by previous reports. Common themes included:

- concerns about costs of care and the future cost impacts of projected demographic change and changing patterns of illness;
- concerns about an over-emphasis on treatment rather than prevention, promotion and maintenance;
- concerns about fragmentation and lack of coordination;
- belief that community services are more responsive to individual and community needs and to the needs of "special" and disadvantaged groups; and
- desirability of non-institutional care compared to institutional care.

There was a high degree of congruence between the rationales for community services offered in previous reports, and those we heard from members of Premier's Council Health Care System Subcommittee and the participants in the expert panel conference. This was interpreted as confirming the fundamental soundness of directions articulated in previous reports.

Issues and problems

The study identified shortcomings of the existing system and anticipated pressures that provide further impetus for seeking to strengthen community services. These included:

- imbalances in the existing health care system;
- adverse impacts of demographic change;
- changing patterns of illness;
- need to spread the responsibility for health and health care;
- discrepancies between health and social service models;
- rigidity of funding programs;
- secondary status of community services; and
- unrealistic expectations of community services.

Community costs compared to institutional costs

It is often argued that community services represent a less costly alternative to institutional care. After examining this question closely we concluded:

- it is too simplistic to think of community services primarily as a cost-effective alternative to institutional services. In some cases they are, in some cases they may be, and in others they are not comparable;
- there is only a partial congruence between community service populations and institutional service populations. For many types of community services, their purpose does not involve serving groups who would otherwise be in institutions;
- where there is some degree of overlap between community and institutional services (such as long-term care), a narrow approach that focuses exclusively on the role of community services as a cost-effective alternative may ignore other important considerations, including quality of life, flexibility, client independence, family burden and fundamental preference.

Vision

We propose a vision for a strong, responsive and effective community services sector, one comprising services with the following characteristics:

- services which respond to the unique needs of the community they serve;
- services which set out to help individuals live with the greatest possible degree of independence in their own communities;
- services which are accountable to the community and are not externally controlled; and
- services which are delivered in a manner that empowers communities and individual consumers.

We identified four key values that should be reflected in the community services sector:

- dignity;
- choice;
- equity; and
- cost-effectiveness.

In achieving this broad vision, three major directions are proposed:

i) to enhance the responsiveness, accountability and effectiveness of community services by:

   - expanding the scope of community services with greater emphasis on promotion, prevention and health maintenance.
   - achieving more flexible program funding and delivery methods;
   - vesting greater power and responsibility in the community sector; and
   - achieving broader use of and participation in community services.

ii) to achieve recognition that the community services sector can make a contribution to health that is at least as significant as that of the institutional sector.

iii) to make the institutional sector more responsive to the community sector and to community needs.

Obstacles

The study noted several obstacles that have contributed to the failure to fully implement the recommendations of previous reports:

- public complacency regarding the need for change in the health care system;
- inadequate attention to community services in professional education;
- lack of awareness of community services;
- treatment of community services as an "add on";
- lack of implementation savvy; and
- pressure for hospitals to assume more specialized roles diminishing their broader general community roles.

Facilitating factors

On the more positive side, we also identified several aspects of the current environment that offer opportunities for achieving change:

- establishment of the Premier's Council on Health Strategy;
- expression of political will;
- imperatives of the fiscal environment;
- recognition of the need to anticipate growing demand for health care;
- new organization of the Ministry of Health; and
- Management Board's Review of the Health and Social Service Program Structure.

Recommended initiatives

The study proposed policy and programmatic initiatives that would help to realize the three directions emerging from the vision and address obstacles to implementation. Within each initiative, numerous actionable proposals were also put forward.

Recommended initiatives for the organization of services were:

- rationalization and local planning of community services;
- partnerships and collaboration;
- enhancing access to community services; and
- encouraging new sponsors for community services.

Recommended initiatives for funding were:

- integration of funding streams;
- more secure funding of community services; and
- local funding envelopes.

Recommended initiatives for training and manpower were:

- creation of attractive professional career opportunities in community services;
- joint professional/government manpower planning; and
- requirements to educate professionals to practice in community settings.

Recommended information and support building initiatives were:

- marketing and information on community services;
- heightening public awareness of current and impending problems in the province's health care delivery;
- fostering development of a strong, organized voice for community services; and
- support for community services research and evaluative studies.

Implementation framework

Finally, the study proposed an implementation framework to ensure well defined acountability structures and processes for implementation. It was recommended that the Premier's Council establish a Community Services Implementation Secretariat to assume responsibility for overseeing the implementation process. This would include coordinating and monitoring implementation of recommended initiatives.

INTRODUCTION

BACKGROUND

The importance of strengthening community services has been a recurrent and well argued theme in discussions on health policy in Ontario. It can be traced through a succession of reports and task force recommendations that go back to the early 1970's and even further back to before the introduction of health insurance in the province. Interest in community services was recently underlined by three major policy reviews which reported in 1987:

- Ontario Health Review Panel (chaired by John Evans);
- Panel on Health Goals for Ontario (chaired by Robert Spasoff); and
- Minister's Advisory Group on Health Promotion (chaired by Steve Podborski).

In spite of the consistency over time of recommendations for enhanced community services, most of the recommendations have not been realized. The Ontario Health Review Panel noted " .... with concern that well founded recommendations made by credible groups over a fifteen year period have rarely been translated into action".[1]

Ontario's experience is not unique. The 1980 Hall Report commented with reference to Canada as a whole:

The concepts of community health care have been stressed by every important study in Canada since the mid-fifties .... The responses to these strongly buttressed proposals have been disjointed, sporadic, often uncoordinated and adopted unevenly among the various provinces.[2]

Further afield, a report of the United Kingdom Audit Commission in 1986 appropriately called *Making a Reality of Community Care* notes that "The policy of successive (British) governments has been to promote community based services". However, it notes:

There are serious grounds for concern about the lack of progress in shifting the balance of services towards community care. Fundamental underlying problems need to be tackled ...[3]

In this context, the Health Care System Subcommittee of the Premier's Council on Health Strategy identified the strengthening of community services as a priority in improving Ontario's health care system. It was the view of the Committee that the principle challenge is not so much to develop new strategies for delivering community services but to understand why past recommendations have not been implemented and to identify strategies to ensure wholehearted implementation of such recommendations for the future. To this end, the Subcommittee commissioned this study to assist in developing a recommended approach for the future development of community services in the province, and in particular, to investigate available options (the terms of reference for the study make up Appendix A).

The study involved several stages:

- preparation of a draft vision statement for community services;
- development of an inventory describing existing types of community services;
- interviews with leading spokespersons and commentators in government, health care, public interest organizations and academia;

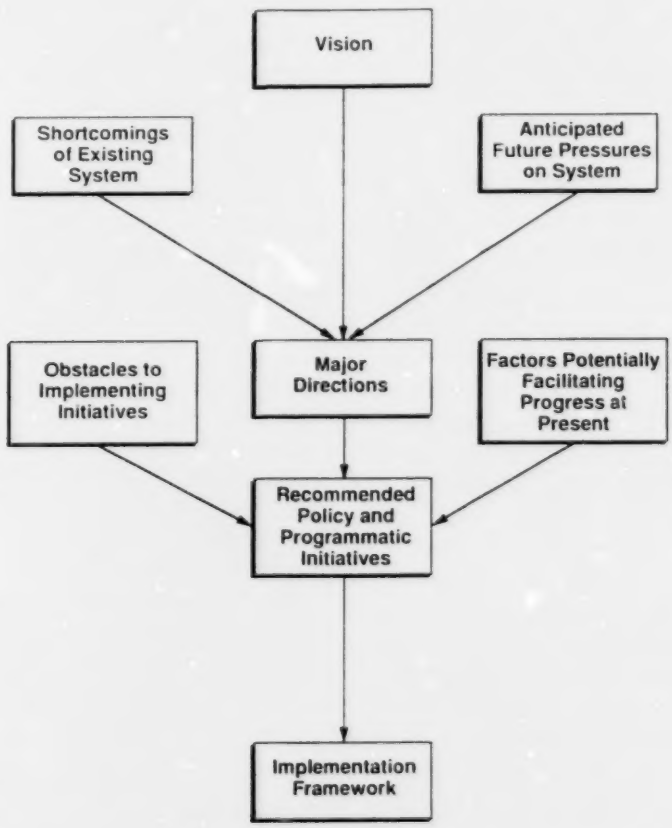
1. John Evans (chairperson), *Toward a Shared Direction for Health in Ontario*, Report of the Ontario Health Review Panel, Toronto, 1980, p.i.
2. Hon. Emmett Hall (Special Commissioner), *A Commitment for Renewal: Canada's National-Provincial Health Program for the 1980's*. Report to the Minister of National Health and Welfare, Ottawa, 1980, p 70.
3. United Kingdom Audit Commission, *Making a Reality of Community Care*, HMSO, London, 1986.

- a review of literature on community services;
- preparation of a discussion paper on potential policy and program initiatives and implementation strategies;
- an expert panel of invited participants on potential initiatives and implementation strategies; and
- preparation of a study report for presentation to the Council.

Analytic Model for the Community Services Study

In conducting the Community Services Study, we followed the analytic model presented in Exhibit I. It begins with the articulation of a vision for community services. On the basis of this vision, as well as an assessment of both the shortcomings of the existing health system and future pressures on the system, we identify major directions. More specific policy and programmatic initiatives are then proposed to accomplish the major directions. In order to enhance the success of these initiatives, consideration is also given to implementation obstacles and to factors that could facilitate implementation.

EXIBIT 1: ANALYTIC MODEL FOR THE COMMUNITY SERVICES STUDY



DEFINITION AND SCOPE

In spite of the broad support for enhancing community services, there is no single commonly accepted definition of community services, nor is there a commonly held understanding of the role of community services. Some of the alternative definitions of community services include:

- services that are provided in a home-based or community setting, as opposed to in-patient and institutional settings;
- services that respond to the unique health needs of communities and the individuals they comprise;
- services that are intended to enable people to live with the greatest possible degree of independence in the community; or
- services that are directed by, and controlled by, the community as opposed to services that are externally controlled or bureaucratic in nature.

In setting out to define community services, the question is also begged as to the relationship between community services and institutional services:

- can community services include services provided by hospitals and the institutional sector?
- is there a distinction that can be made between a primary care role to be fulfilled by community services and secondary care roles that the institutional sector should assume?
- to what extent is it desirable to integrate the organization of community services and institutional services, or should the two sectors be organized to operate in a state of cooperative, friendly competition?

For this study, we have adopted a definition of community services that sees community services as services that are defined primarily in terms of their focus, locale, accountability and who provides the services:

- the *focus* is on individual independence, local health needs, and the achievement of direct impacts on health;
- the *locale* for the provision of services is the home or the local community;
- *accountability* for planning, management and results of the services lies with the local community and those who provide the services;
- the *providers* of services include professionals, non-professionals and volunteers.

This definition does not rule out the services of community hospitals or even particular services offered by a tertiary care hospital which are outreach or community-oriented in nature.

To help clarify this definition of community services, we have identified the principal types of service involved. They include:

- professional home health services;
- home support services;
- community mental health services;
- day care;
- community rehabilitation services;
- ambulatory care;
- primary care;
- health promotion/prevention;
- occupational health services; and
- coordination and referral services.

Each of these service areas is outlined in Appendix B of this report. As can be seen from this list of service types, our definition of community services comprises both services which have a direct impact on health and those with indirect impacts. However, the study focusses, in particular, on those services with direct health impacts.

Later sections of this report on "analysis of rationale" and "vision" will serve to provide a more complete understanding of the dimensions of community services as defined in this study.

ANALYSIS OF RATIONALE

The starting point for this study is a long list of both Canadian and Ontario reports that have advocated the enhancement of community services. Their recommendations represent the impetus for our analysis. In this section, we examine the reports and the recommendations they make regarding community services, and analyze the rationale they follow in arriving at their conclusions.

A summary of the key findings and recommendations from major Canadian and Ontario reports on health care delivery since 1970 is provided in Exhibit 2. It covers eight reports and demonstrates the amount and consistency of attention given to community services over a period of nearly two decades.

The summary of recommendations provided by Exhibit 2 reveals several general themes:

- promotion and planning of primary care;
- alternative models of primary care, such as community health centres and health service organizations;
- emphasis on alternatives to institutional care;
- emphasis on prevention and promotion;
- pluralism and innovation;
- service integration and coordination; and
- improved access.

Similarly, there are common threads that run through the rationales offered for such recommendations:

- concerns about costs of care and the future cost impacts of projected demographic change and changing patterns of illness;
- concerns about an over emphasis on treatment rather than prevention, promotion and maintenance;
- concerns about fragmentation and lack of coordination;
- belief that community services are more responsive to individual and community needs and to the needs of "special" and disadvantaged groups; and
- desirability of non-institutional care compared to institutional care.

It is of interest that most of the reports saw community services as a way to deal with future cost crises, crises expected to be brought on by demographic change, new technology and a growing burden of chronic illness. Thus, in as far as a cost rationale for community services is offered, it is in terms of future oriented cost avoidance. Only one report, the 1983 Ontario Council of Health Report, indicated a belief that community services offer a cost-effective alternative to institutional care that could be realized in the short-term. Interestingly, it was reporting the conclusions of a public consultation process rather than findings based on analysis.

Virtually all these reports see community services as intrinsically more responsive services which, by the nature of their service setting (home and community), entail services that are desirable and contribute to the quality of life. The emphasis on community is clearly value-driven. Given a choice, between receiving services in the community or an institution, in most situations each of us would unhesitatingly choose the community option. It is a fundamental preference. The emphasis on community, then, is not simply the product of a cost rationale, or concern about administrative integrity.

We find a high degree of congruence between the rationales for community services offered in previous reports and those we heard from members of the Premier's Council Health Care System Subcommittee and the expert panel held for this study. We interpret this as confirmation of the fundamental soundness of directions articulated in previous reports and of the importance of addressing any obstacles that have up till now inhibited the full implementation of these recommendations.

EXHIBIT 2: CANADIAN AND ONTARIO REPORTS RECOMMENDING STRENGTHENED COMMUNITY SERVICES 1972 - 1987 FINDINGS AND RATIONALE

REPORT	KEY FINDINGS AND RECOMMENDATIONS ON COMMUNITY SERVICES	RATIONALE
John Hastings (chair), *The Community Health Centre in Canada*, Report to the Conference of Health Ministers, Ottawa, 1972	• development of community health centres as non profit corporate bodies in a fully integrated health system • reorganization and integration of all health services into a health service system to ensure basic health services standards for all Canadians	• concern about accelerated rate of spending on health services and a belief that community health centres are an important means for slowing the rate of increase in costs by shifting emphasis from hospital inpatient care by using a more efficient mix of health resources and health professionals. • bringing community resources to bear to solve people's health and related problems. • reducing fragmentation and duplication of services. • potential for health education.
Edward Pickering (Project Director), *Special Study Regarding the Medical Profession in Ontario*, report to the Ontario Medical Association, Toronto, 1973	• intensification of efforts to enlarge the role of paramedical services. • study the possibilities of home care for the disabled as an alternative to a life time of confinement in institutions. • support for physician group practices and greater physician cooperation with other health professionals. • reexamination of the health care delivery system	• fragmentation and lack of coordinated management of patient problems. • recognition of limits to what individual physicians can take on. • need to respond to patient needs. • reducing health care costs.
Fraser Mustard (Chairman), *Report of the Health Planning Task Force*, for the Ontario Minister of Health and Cabinet Committee on Social Development, Toronto, 1974.	• development of primary care to ensure: - 24 hours a day, seven days a week access; - inclusion of health promotion and prevention measures;	• need to develop a comprehensive health care system. • development of primary care with effective coordination and integration with the secondary care sector.

EXHIBIT 2: CANADIAN AND ONTARIO REPORTS RECOMMENDING STRENGTHENED COMMUNITY SERVICES 1972 - 1987 FINDINGS AND RATIONALE

REPORT	KEY FINDINGS AND RECOMMENDATIONS ON COMMUNITY SERVICES	RATIONALE
	- appropriate use of health services; - evaluation and peer review. • establishment of District Health Councils across the province. • development of Area Health Services Management Boards. • Regional Directors for health services appointed by the Minister. • District Health Council involvement in local manpower planning and physician registration under the Ontario Health Insurance Plan. • Clinical education of health personnel to include practice in both the primary and secondary care sectors.	• guiding principles: availability, accessibility, continuity, focus of system, range of services, efficiency, integration and coordination, innovation, evaluation, decentralization, pluralism, evaluation. • problems: concentration of speciality services in hospitals, random distribution of physicians in relation to community needs, lack of coordination, inadequate access in certain areas of the province. • inadequacy of health resources to meet anticipated future needs/demands.
Hon. Emmett Hall (Special Commissioner), *A Commitment for Renewal: Canada's National Provincial Health Plan for the 1980's*, Report to the Minister for National Health and Welfare, Ottawa, 1980.	• concentrate new spending on both prevention and promotion on the one side and functional support services on the other with major emphasis on non institutional services. • federal, provincial and territorial governments should agree upon and plan a fully coordinated program embracing all elements of Community Health Care.	• over concentration on "curative" and "treatment" services. • lack of coordination and planning.

EXHIBIT 2: CANADIAN AND ONTARIO REPORTS RECOMMENDING STRENGTHENED COMMUNITY SERVICES 1972 - 1987 FINDINGS AND RATIONALE

REPORT	KEY FINDINGS AND RECOMMENDATIONS ON COMMUNITY SERVICES	RATIONALE
Fraser Mustard (Chairman), *Report of the Task Force to Review Primary Health Care,* Report to the Minister of Health, Toronto, 1982	• allow for development of variety of arrangements for the provision of primary health care. • Health Service Organizations and Health Centres should be accepted as legitimate models for the delivery of primary care. • incentives for primary care agencies to reduce hospital use should be extended. • high priority should be given to planning of primary care services and District Health Councils should be involved. • Ministry should establish a task group to conduct a more indepth review of the primary care sector.	• community health services have significant impact on the quality of human life. • anticipated growth in demand with increased proportion of elderly in the population and changing disease burden. • need to deal with inequalities in access to health care and inequalities in health. • effectiveness of primary health care will determine the future quality, efficiency of the province's health care system.
Ontario Council of Health, *Health Care: the 80s and Beyond,* Report of the Minister's Policy Conference, Toronto, 1983.	• development of community based programs and education as an alternative to traditional hospital based care. • improved provider education to better prepare health professionals to work in and emphasize community-based services. • support for community based services through funding and incentives.	• belief that community based programs would provide a less costly alternative to institutionalized care. • community based services are more individual oriented. • "neighbourhood focus" and better ability to respond to special needs.

EXHIBIT 2: CANADIAN AND ONTARIO REPORTS RECOMMENDING STRENGTHENED COMMUNITY SERVICES 1972 - 1987 FINDINGS AND RATIONALE

REPORT	KEY FINDINGS AND RECOMMENDATIONS ON COMMUNITY SERVICES	RATIONALE
Health and Welfare Canada, *Strengthening Community Health Services* discussion paper prepared by the Community Health Services Division, Ottawa, 1986.	• enhance community involvement through participation in service planning, facilitating volunteers and support for mutual aid. • target community health services to underserviced groups. • increase emphasis on health promotion and disease prevention. • facilitate coordination of community health services through coordination with social services and linkages with institutional services	• strain arising from changing patterns of demography and disease. • need for services that: respond to major health problems, are cost-effective, respond to community needs, and are accessible.
John Evans (Chairman), *Toward a Shared Direction for Health in Ontario*, Report of the Ontario Health Review Panel, Toronto, 1987.	• link elements of health care delivery. • increase emphasis on ambulatory and community-based care.	• respond to pressures on health care budget. • cost-effectiveness, minimizing high cost inpatient institutional care. • improvement in quality of health care. • integration of treatment and prevention. • enhanced access to appropriate care.

ISSUES AND PROBLEMS

There are several concerns regarding the health care system that provide further impetus for seeking to strengthen community services. Some of these concerns relate to shortcomings of the existing system such as imbalances in the distribution of health care resources and the need to achieve a more appropriate spread of responsibility for health and health care. Other concerns relate to anticipated pressures on the health care system such as the adverse impacts of projected demographic change and changing patterns of illness.

- **Imbalances in the existing health and health care system.**
  There is growing recognition that the current health care system places too great an emphasis on sickness rather than health.[4] There are concerns about the appropriateness of the current concentration of resources in institutional and traditional forms of medical care. Eighty-five percent of the provincial government's spending on health care is devoted to hospitals and physicians. If we exclude physician services that are not provided in hospitals, the figure is still over 60%.[5] A health care delivery system which continues to rely heavily on institutional forms of service delivery will result in health care which will be increasingly expensive. Opportunities will continue to be missed to prevent illness and to reduce the need for health care. Concerns about the over-concentration of health resources in the institutional sector are reinforced by data from other jurisdictions which suggest that between 10% and 25% of our health budget is being spent on health care for individuals in their very last year of life.[6] Questions are raised as to whether such expenditure patterns are consistent with social policy objectives which stress quality of life - the notion that we should be adding life to years, not just years to life. Concerns about such imbalances in the health care system also raise questions as to the limits of what can be accomplished through the institutional sector, and whether we may, in some areas, have exceeded such limits.

- **Adverse impacts of demographic change.**
  The number and proportion of elderly in the population is projected to grow dramatically in the upcoming decades. While the population of Ontario as a whole will grow by only 17% in the next 25 years, the number of people aged 65 years and over will increase by 75%.[7] The elderly use disproportionately more health services than the rest of the population. Researchers have shown that if we continue to use hospitals at current rates, the entire current hospital capacity of the country will be needed just to serve the elderly by the second decade of the next century.[8] Thus, projected demographic changes make it highly desirable to achieve a shift in the emphasis of health care delivery away from institutional to community services. The alternatives to such a shift to community services are to spend large amounts on the construction of additional institutional capacity, or to invite a situation where we lack the capacity to respond to those with health care needs.

4. see, for example, speech by Hon. Elinor Caplan, Minister of Health, to the Ontario Hospital Association Annual Meeting, Toronto, Ontario, December 2, 1987.
5. Ministry of Health data, 1987-88.
6. Noralou P. Roos, Patrick Montgomery, and Leslie Roos, "Health Care Utilization in the Years Prior to Death", *Milbank Quarterly*, Vol 65, No. 2 1987, pp. 231-254.
7. Statistics Canada, *Population Projections for Canada, Provinces, and Territories*: 1984-2006, Ottawa, 1985.
8. Canadian Medical Association, *Task Force on the Allocation of Health Resources: Investigation of the Impact of Demographic Change on the Health Care System in Canada*, Ottawa, 1984, and
   L.A. Lebvre, Z. Zsigmond and M.S. Devereaux, *Prognosis for Hospitals*, Ottawa, Supply and Services Canada, 1979.

- **Changing patterns of illness.**
  The case for shifting the emphasis of health care to community services is also supported by data on changes in patterns of illness. Research shows that more and more illness and disability is accounted for by chronic diseases of long-term duration, rather than acute illnesses.[9] About nine-tenths of all years of impaired health experienced by individuals is due to various categories of long-term disability.[10] It has also been shown that about two-thirds of each life year gained through increases in life expectancy over the last 25 years was spent with some degree of disability.[11] These trends imply that, if significant progress is to be achieved in improving the quality of life for those who are ill and impaired, greater emphasis should be placed on long-term care and rehabilitative services. Such services should give priority to supporting individuals in the community, enabling them to be as independent as possible and to come as close as possible to leading normal lives.

- **Need to spread the responsibility for health and health care.**
  A new view of health and health care is emerging. In the interest of moving beyond a narrow sickness orientation to health care, there has been a growing recognition of the need for health policies to address the positive aspects of health and wellness.[12] This would include taking into account broader environmental factors which contribute to good health. Under such a view, responsibilities for health care are spread more widely, including not only health service providers, but also consumers, families, educators, employers, labour and industry.

- **Discrepancies between health and social service models.**
  Much has been said about the gaps and discontinuities arising from having two separate government ministries for health and social services.[13] It has, for example, presented an issue in relation to long-term care services for the elderly and disabled. The inventory of service types (Appendix B) shows how extended care, home care and home support programming are each divided between the two ministries. However, the issue goes beyond the administrative separation of the ministries and appears in the different orientations of health programming compared to social programming, as well as the contrasting norms and approaches of health professionals compared to social service professionals. Clearly, there is a need in health/social border areas – such as long-term care, home care and home support, mental health, and addictions – to adopt integrated or coordinated health and social service strategies. These strategies will need not only to entail more comprehensive approaches to service delivery but they should also bring together and capitalize on the strengths of both health and social service professionals.

- **Rigidity of Funding Programs.**
  The funding and administration of community services in Ontario has been characterized by a series of distinct government programs, each funding different types of health and social services. This arrangement has resulted in a compartmentalized service system. It has also made it difficult for innovative services to be developed that attempt to cut accross the lines drawn by funding programs. Some Community Health Centres,

9. Institute for Health Care Facilities of the Future, *A View of the Horizon*, Ottawa, 1987, pp 9-19.
10. Russ Wilkins and Owen Adams, *Healthfulness of Life: A Unified View of Mortality, Institutionalization, and non Institutional Disability in Canada*, Montreal, Insitute for Research on Public Policy, 1984.
11. Morris Barer, Robert Evans, C. Hertzman, and J. Lomas, "Toward Efficient Aging: Rhetoric and Evidence," paper for the Third Conference on Health Economics, Winnipeg, May 1986.
12. Hon. Jake Epp, *Achieving Health for All: A Framework for Health Promotion*, Health and Welfare Canada, Ottawa, 1986, and Joan Watson, (chair), Canadian Medical Association, *Health: A Need for Redirection, Task Force on the Allocation of Health Resources*, Ottawa, 1985 pp. 119-128.
13. Ontario Health Review Panel, *Toward a Shared Direction for Health in Ontario*, Toronto, June 1987, pp.13-14.

for example, have in the past experienced difficulties securing funding for services that have a health education and health promotion purpose because of expectations that such centres should be focussing on more traditional primary care services. The disconnectedness of funding streams also serves to inhibit the better collaboration of community services with institutional services.

- **Secondary status of community services.** The full importance and contribution of community services is often not appreciated by the public funding agencies, or professionals themselves. Services that involve primary care, support in the home, occupational health and so on are difficult to evaluate and tend to appear to be less consequential than the more dramatic interventions such as major surgery and trauma treatment that are associated with hospital care. A life saved through a transplant operation captures the imagination more than a life saved through accident prevention or lifestyle modification. Such biases are apt to be reflected in the allocation of funds, as well as the prestige and status ascribed to the two sectors.

- **Unrealistic expectations of community services.** Community services are frequently justified in relation to their role as a substitute for institutional care. However, a quick scan of the inventory services in Appendix B shows that many community services do not have any objectives concerning substitution for institutional care, nor is there any reason why they should. Robert and Rosalie Kane remark:

Community care is needed! Too often this topic has been approached with the expectation that such care will substitute for institutional care. The evidence ..... rather clearly demonstrates that such is generally not the case. The home is the preferred site of care for many clients. Community care should be conceived as a natural response to the need for support. It is a resource in its own right, not an alternative form of care. If anything, the institution should be considered the alternative to the community, to be used when community care is no longer feasible.[14]

14. Rosalie Kane and Robert Kane, *Long-Term Care: Principles, Programs and Policies*, Springer Publishing: New York, 1987, p.379.

ARE COMMUNITY SERVICES LESS COSTLY?

It is often assumed that it costs less to serve individuals in the community than in inpatient and institutional settings. This assumption is used to justify greater emphasis on community services. However, it deserves closer scrutiny. To begin, we can differentiate among community services according to the relationship that is likely to exist between community and institutional costs:

- **Lower costs.**
  Some community services unequivocally represent lower cost alternatives to care in institutional settings. Examples include certain ambulatory surgery procedures such as outpatient cataract surgery;
- **Lower, same or higher costs.**
  Some community services represent cost-effective alternatives for some patients while for others they are more expensive than institutional care. These include services that can be provided in varying degrees of intensity such as home care;
- **Not comparable.**
  Some community services do not represent alternatives to institutional care and the question of cost- effectiveness is, therefore, moot. An example of this type of service is a community health centre established to provide improved access to primary care for disadvantaged populations.

The cost implications of community services can also be influenced by access to alternative institutional services. With institutional care, there is a tendency under current funding systems for any existing beds to be occupied. Milton Roemer has propounded a law of health service delivery which holds that "increased institutional supply induces its own demand." [15] Thus, if a community service is introduced with the intent of achieving cost savings, it may not be possible to realize these savings unless the supply of institutional care is managed in a fashion that permits the potential savings to be realized.

Another confounding dynamic is that of "add-on" clientele. A program can be intended to provide an alternative to institutional care, but it may be difficult to limit its use to those who, but for the community service, would have used institutional care. Ambulatory cataract surgery, for example, may be made available to people for whom the traditional institutional based treatment would have been ruled out. With greater access to outpatient surgery, and the less traumatic nature of new procedures, individual patients may seek surgery sooner in the progression of the problem and may have the procedure performed more often in their life-time. In another example, home-maker services intended to prevent or reduce need for institutional care may be used by people who would refuse to use institutional services even when they are eligible for them. This "add-on" phenomenon can be addressed, in part, through better targeting of services at those individuals at greatest risk. However, targeting involves higher administrative costs.

As this discussion illustrates, the question of the cost-effectiveness of community services is a complex one. Despite extensive research on the topic, there is no simple empirically derived conclusion that can be offered. Even the most elaborate research studies have been limited to just one or a few types of service, have been specific to one or a few geographic areas and have been of relatively short duration. In the face of some research findings indicating limitations to the cost-effectiveness of particular community services, proponents have noted that the research was conducted in jurisdictions where the findings might not be generalizable to Ontario and that the studies have only lasted, at most, a few years and therefore would not detect any longer term effects in terms of cost-avoidance.

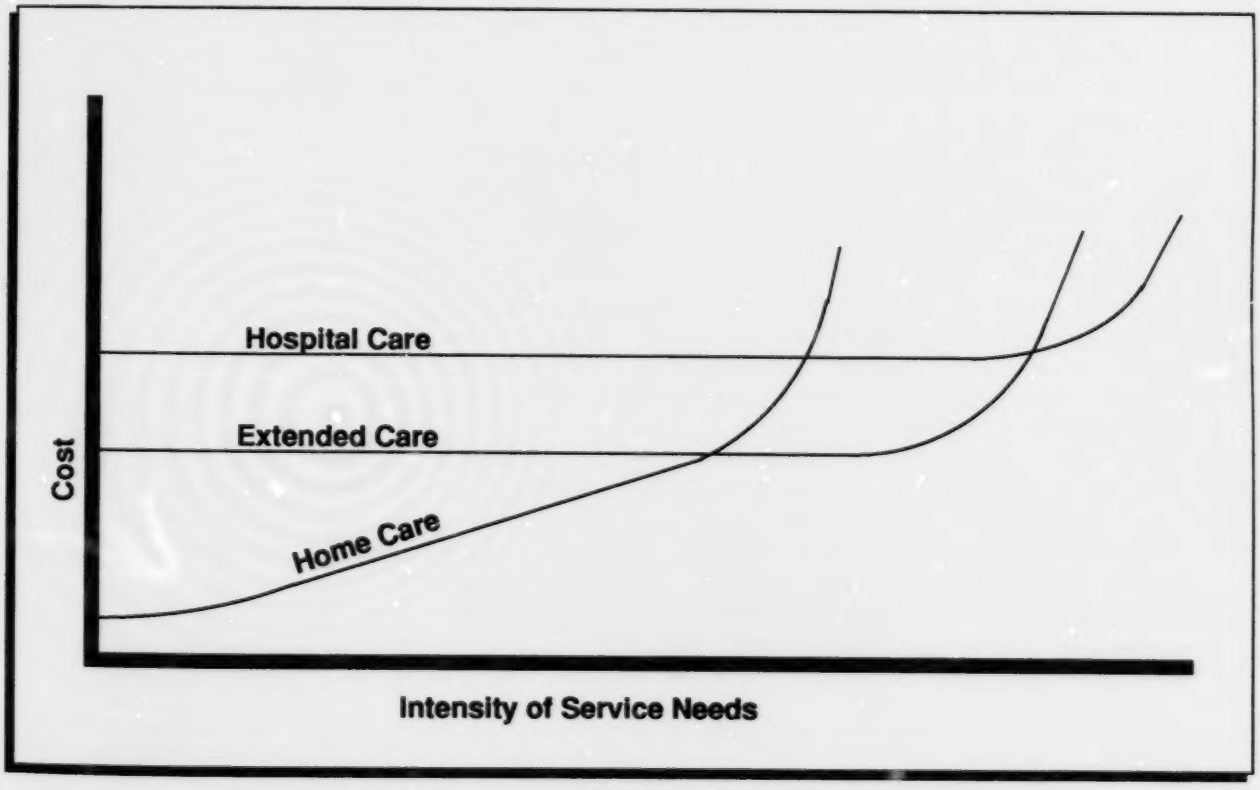
15. Milton I. Roemer, "Bed Supply and Hospital Utilization: a Natural Experiment," *Hospitals: Journal of American Hospital Association*, November 1961, pp 36-42.

The Case of Home Care

To provide a better appreciation of the issue of the cost-effectiveness of community services, let us examine the case of home care. Home care generally refers to health services and services to support independent living that are provided to clients in their homes. In Ontario, we have a well developed program that covers virtually the entire province. It consists mainly of visiting nurse services, services of rehabilitation professionals and homemaker services. These services are provided on an "acute" basis to short-term patients to facilitate earlier hospital discharge or even prevent the need for an admission. They are also provided on a "chronic" basis to clients requiring longer-term rehabilitation or maintenance (the Program is described more fully in Appendix B, the inventory of service types).

The question is frequently raised as to whether home care services represent a cost-effective alternative to institutional forms of care. No studies have yet been conducted on the Ontario program which provide conclusive evidence on this question. However, it is possible to deal with the question both at a conceptual level and with reference to research findings from other jurisdictions. At the conceptual level, a schema for consideration of home care costs is provided in Exhibit 3.

Exhibit 3 : Comparison of home care costs in relation to intensity of service needs with the costs of hospital care and extended care.



The schema shows, in a simplified manner, how care costs vary in relation to the intensity of service needs. Because home care does not involve high fixed costs for buildings and equipment, it is more cost-effective for those with less intensive service needs. However, as service needs intensify, the cost advantages of institutional care resulting from concentration of services and avoidance of provider travel time begin to outweigh the fixed costs. Thus, there are breakeven points above which the needs of a client can be more cost-effectively met through extended care or hospital services.

Because the question of the cost-effectiveness of home care is fundamental to the design of systems of acute and long-term care, it has received extensive research attention in some other jurisdictions, most notably in the United States. In fact, the research literature on cost-effectiveness is probably better developed for home care than for any other health service type. A recently published review of 31 major American community service demonstration projects in the long-term care sector concluded that ".... such (homecare) services usually raise overall health care service use and costs."[16] However, the authors note that the cost-effectiveness of community services can be enhanced where services are very explicitly targeted at those at high risk of institutionalization and particularly when they are linked to a mandatory preadmission screening program for institutional long-term care. However, such findings also raise a policy question as to whether it is desirable to limit home care services only to those who would otherwise be in institutions.

In another review of research in this field, William Weissert provides an analysis of why many of the assumptions regarding the potential cost-effectiveness of community based long-term care are not warranted:

..... Few who use home- and community-based long-term care would otherwise have been long-stayers in nursing homes. Long-stayers tend to be older, sicker, more dependent, and poorer in social resources than those who use community care. Fewer still who use community care actually have their institutional stay averted or shortened by its use, even if they are at risk. But more effective targeting on those most likely to be institutionalized may lead to high screening costs and small , inefficient programs, because few patients in the community fit the profile for high risk of institutionalization. Conversely, the very sickest and most dependent patients may be cheaper to serve in a nursing home than in the community..... Nonetheless, community care serves a sick, dependent, and – most people would agree – deserving population of patients and their caretakers.[17]

Faced with this research evidence, many policy analysts and scholars in the field have begun to argue strongly that it is a mistake to justify home care simply on the basis of it serving as a cost-effective alternative to institutional long-term care. Robert and Rosalie Kane criticize what they refer to as the "alternatives mentality". They recognize that research shows:

...there was an impressive consistency in the findings: Many patients could be managed in the community, but doing so did not produce a cost-effective alternative to nursing homes.

However, they argue:

These findings do not mean that community care is not a worthwhile goal. Rather, they suggest that community care should be pursued as an end in itself when it is the mode preferred by the citizenry. The lessons of the United States demonstration projects come in the form

16. William Weissert, Cynthia Mathews Cready and James Pawelak, "The Past and Future of Home - and Community-Based Long-Term Care," *The Milbank Quarterly*, Vol 66, No 2, 1988, pp 309-388.
17. William Weissert, "Seven Reasons Why it is so Difficult to Make Community Based Long-Term Care Cost-effective," *Health Services Research*, 20:4 October 1985, pp 423-433.

of cautionary notes. They show the fallacy of evaluating home care by its overall cost-effectiveness as a substitute for care in nursing homes; this could only be achieved by limiting home care to persons willing to enter a nursing home–an absurd criterion.[18]

The focus of most of the recent home care research in the United States has been on its cost-effectiveness for long-term care populations.

However, there is also considerable research, including some from Canada, on the cost-effectiveness of home care for short-term medical and post-operative cases.[19] The results of these studies suggest that for some patient categories, although by no means all of them, the overall costs of care can be reduced through earlier hospital discharges to home care. There is also evidence that advances in medical technology and increasingly portable technologies have greatly increased the potential for using home care as a replacement for acute hospital care.

SUMMARY

There are several lessons for this study that emerge from this discussion of cost-effectiveness:

- it is too simplistic to think of community services primarily as a cost-effective alternative to institutional services. In some cases they are, in some cases they may be, and in others they are not comparable;
- there is only a partial congruence between community service populations and institutional service populations. For many types of community-service, their purpose does not involve serving groups who would otherwise be in institutions; and
- where there is some degree of overlap between community and institutional services (such as in long-term care), a narrow approach that focuses exclusively on the role of community services as a cost-effective alternative may ignore other important considerations, including quality of care, flexibility, client independence, family burden and fundamental preference.

18. Robert Kane and Rosalie Kane, "Lessons from experiences in other jurisdictions", paper commissioned by Price Waterhouse to support *The Review of the Manitoba Continuing Care Program*, April 1988, pp 12-14.
19. L. W. Gerson and J. F. Collins "A Randomized Controlled Trial of Home Care: Clinical Outcomes for Five Surgical Procedures," *Canadian Journal of Surgery*, Volume 19, No 6, 1976, pp 477-478, and
A. M. Clarfield, "Home Care: Is it Cost-effective?" *Canadian Medical Association Journal*, Vol 129, December 1, 1983. pp 1181-1199, and
John Hammond, "Home Health Care Cost-effectiveness: An Overview of the Literature," *Public Health Reports*, Vol 94, No 30, July-August 1979, pp 5-11, and
Stephen Cang "An Alternative to Hospital", *Lancet*, April 2, 1977, pp 742-743.

VISION

We propose a vision for community services that involves a strong, responsive and effective community services sector, one that is committed to maximizing health and, in the long-term, minimizing the need for expensive institutional services. Our vision represents a departure from the existing fragmented, compartmentalized and undeveloped pattern of community services. It sees a strong, responsive and effective community services sector as one that comprises services with the following characteristics:

- services which respond to the unique needs of the community they serve;
- services which set out to help individuals live with the greatest possible degree of independence in their own communities;
- services which are accountable to the community and are not externally controlled; and
- services which are delivered in a manner that empowers communities and individual consumers.

The proposed vision sees the community services sector existing side by side with the institutional sector. We see community services as services that exist in their own right. We recognize that the population served by community services and institutions is not congruent, although some overlap does exist. Clearly, community services need to collaborate with the institutional sector and appropriate linkages have to be forged between the two sectors and between components of the two sectors. However, our vision for community services rules out the amalgamation or the total organizational integration of the two sectors. We do not want to see the co-option of community interests by the institutional sector.

Community services should not be seen as services which only serve selective target populations. Community services should represent a major part of mainstream health care. They should not be viewed as some alternative, "yoghurt and granola" form of health care which the average person has little use for. It is not our intention to promote a few islands of alternative health care. Nor is it our wish to reverse recent progress in health care and go back to a more family- and locally-based care which fails to take advantage of the tremendous advances in medical technology and knowledge that have occurred in recent decades. Rather, the concern is with developing broad new approaches to health and health care which build on opportunities created by recent advances in medicine and caring technologies, while also recognizing the importance of community, family and individual resources.

Values for community services

To help elaborate on this vision for community services, we have identified four values that should be reflected in the community services sector:

- **choice.**
  Consumers should be provided with information on their condition and on options which they have for care and treatment;
- **dignity.**
  Services should be provided in a manner which contributes to patients' independence and self-respect;
- **equity.**
  It is important that everyone in the province has access to services that respond to their needs. This does not mean everyone receiving the same services, since needs will vary among individuals and communities;
- **cost-effectiveness.**
  Services should be delivered in a manner that ensures that health and health care objectives are achieved as cost-effectively as possible.

We also identified several other potential values which warrant secondary consideration:

- **quality of life.**
  It is critical that decisions concerning the care and treatment of individuals take full consideration of broader implications for the quality of life, as well as ensuring that they receive care of a high technical quality;

- **enabling.**
  Community services should be seen to comprise not only direct treatment interventions but also initiatives which will strengthen individuals' capability to take care of themselves, and the ability of families and community groups to care for ill or dependent individuals;
- **responsibility.**
  The responsibility for health and health care should be recognized as going beyond traditional health care providers and government to include consumers, families, educators, employers, labour, industry and so on.

The proposed vision and its values shift the spotlight to the individual. They recognize his/her rights and responsibilities to live independently and to maintain his/her health. We see community services entailing a critical balance of the values of choice, dignity and equity, values that are peculiarly specific to the individual.

Three major directions

To facilitate the achievement of this broad vision, we have identified three major directions, that are meant to help translate the vision into action. They represent important thrusts that will serve to strengthen community services. The three directions are:

i) to enhance the responsiveness, accountability and effectiveness of community services by:

- expanding the scope of community services with greater emphasis on promotion, prevention and health maintenance;
- achieving more flexible program funding and delivery methods;
- vesting greater power and responsibility in the community sector; and
- achieving broader use and participation in community services.

ii) to achieve recognition that the community services sector can make a contribution to health that is at least as significant as that of the institutional sector.

iii) to make the institutional sector more responsive to the community sector and to community needs.

OBSTACLES

Section 1 noted that numerous previous task forces and policy studies have made recommendations to strengthen community services. However, many of these recommendations have yet to be implemented. In this section we discuss some of the obstacles that have served to impede their implementation. In the following sections we discuss factors that may currently facilitate implementation and strategies that can be adopted to address implementation obstacles.

- **Public Satisfaction with the Health Care System and Complacency Regarding Pressures for Change:** While public policy discussions have dealt extensively with community services, this has not yet piqued the public's concern with respect to the health system and the problems confronting it. It is widely believed that Canadians (and residents of Ontario) have one of the best health systems in the world. In this context, it is difficult to marshall the public and political will to achieve substantial changes in the emphasis and structure of our health system. As the old adage goes, "if it's not broke, don't fix it." Clearly, there is a need to temper public satisfaction with the past performance of the health system with an understanding of predicted growth in demand, limitations on future health resources, concerns about the cost-effectiveness of certain health care practices and an acceptance of the boundaries as to what the formal health care system can achieve in terms of impacts on health.

- **Inadequate Attention To Community Services in Professional Education:** Education programs and training for health professionals too often give minimal attention to preparing students to practice in community settings. While certain medical and nursing schools have increased the involvement of students in community practicums, others still have not. This lack of attention to community services will continue to limit the number of professionals who are fully equipped to work in a community environment, who consider community services a serious career choice, and who refer clients/patients to community services.

- **Lack of Awareness of Community Services:** Lack of awareness and understanding of existing community services by both health providers and consumers is a critical barrier to the use of community services. Legislation inhibiting health professionals from advertising has prevented community health centres from making their target populations fully aware of the range of services that they offer. Initiatives such as "One-Stop Access" represent a public recognition of the need to address issues of access.[20] However, there is evidence that these initiatives are themselves impeded by the bureaucratic and organizational complexity of this field.

- **Treatment of Community Services as an "Add On":** Community services have been treated by program planners and funding agencies as an "add on" component of the health care system. Community service programs have been introduced in a piecemeal fashion and funded out of separate program streams within the Ministry of Health, with little concerted effort to realizing potential beneficial impacts to other areas of care. This treatment of community services has contributed to a lack of clarity of the role of community services in the health care system as a whole and shortcomings in the integration of institutional and community services.

  An example of this "add on" treatment is provided in the province-wide introduction of the Home Care Program. The program is intended to prevent, delay and reduce institutional use. However, the introduction of the program was not reflected in any planning in the institutional sector that attempted to realize these intended institutional impacts.

20. Ontario, Office for Senior Citizens Affairs, *A New Agenda: Health and Social Services Strategies for Ontario's Seniors*, Toronto, 1986, p 11.

- **Fragmentation:**
  Community services have lacked a coherent vehicle or focus for overall planning and coordination. Numerous government ministries, and within them, numerous programs, have had responsibilities for funding and directing community services. There is a multitude of agencies providing community services. In Metro Toronto alone, there are, by one estimate, over 3,500[21] different community service agencies. With such fragmentation, there is clearly a need for a central instrument or organization to achieve ordered and systematic implementation of new policies.

- **Lack of Implementation Savvy:**
  A major obstacle to the implementation of plans for enhanced community services in general, and individual programs in particular is a failure to fuliy master the process and requirements of policy and program implementation. Specific problems in this regard include: inadequate planning of new services and assessments of their potential implications and impacts; inadequate involvement in policy planning decisions by organizations which will deliver the services of decentralized programs; lack of attention to education and promotion activities concerning new initiatives; a lack of attention to the development of effective linkages between new services and existing community and institutional services; and failure to articulate program objectives and to communicate them to the public, service providers and community agencies.

- **Separation of Principal Funding Streams:**
  Community and institutional services are funded out of separate streams by the Ministry of Health and each type of care must respond to a unique set of reporting and administrative requirements. In addition, some services (e.g. homemaking) are funded by several ministries. This separation of funding streams has contributed to a lack of coordination and integration in service planning initiatives.

- **Pressures for Hospitals to Assume More Specialized Roles Diminishing their Broader General Community Hospital Roles:**
  As hospital technologies have become increasingly more sophisticated and capital intensive, there have been pressures to achieve a more cost-effective distribution of hospital resources through greater specialization and development of centres of excellence. This trend is particularly marked in urban areas. It is serving to inhibit the role of hospitals as a general, community-oriented health resource. It underlines the growing importance of community-based primary care serving to assist in meeting the overall needs of patients and referring them to appropriate specialist services. It also underlines the need for strong planning and collaborative mechanisms among hospitals and community-based providers.

21. Canadian Council on Social Development, *Improving the Delivery of Community Based Health and Social Services*, Report of Conference Proceedings, 1985, p 11.

FACILITATING FACTORS

Despite the experience of past recommendations, and the obstacles to such recommendations, there are several considerations which provide grounds for optimism about renewed efforts to emphasize community services.

- **Establishment of the Premier's Council on Health Strategy.**
  The Premier's Council was established in December 1987 with a mandate that includes the identification of "...initiatives to develop public policy which emphasizes health promotion, disease prevention and alternatives to institutional care". The Council clearly has the committed support of the highest levels of the Ontario Government, reflected in the Premier's leadership of the process. It also brings together representatives of key groups with an interest in the health and health care of Ontario residents. This will assist in ensuring a broader ownership (among different ministries and professional and institutional groups) of recommendations for change.

- **Expression of Political Will.**
  There are a great number of initiatives being promoted by the government at present designed to achieve a managed change in the province's health care system. These include: the Independent Health Facilities legislation, the review of 22 hospitals and related conjoint report, a planned review of Ministry funding procedures for hospitals, new proposals for the role of District Health Councils, the establishment of the Advisory Committee on Multicultural Health, establishment of the Health Innovation Fund, the Task Force on the Use and Provision of Medical Services (Scott Committee), and women's health initiatives. Taken together, these initiatives reflect a high level commitment to comprehensive changes in the province's health care system. The Minister of Health has also articulated and actively promoted a new vision that entails: "equity in access to effective, quality health care, the best that we can afford, as close to home as possible."

- **Imperatives of the Fiscal Environment.**
  The 13% growth in the Ministry of Health's budget in the last fiscal year led directly to the Treasurer's decision to raise the provincial sales tax by one percentage point to 8%. The proportion of the provincial government's budget devoted to the Ministry of Health has gone from 26% to 33% over a ten year period. At the same time, the federal government has curtailed the extent to which it will share provincial health expenditures.[22]

- **Recognition of the Need to Anticipate Growing Demand for Health Care.**
  There is an increasing public perception that projected demographic changes and associated growth in the demand for health care pose a future crisis for health care delivery unless alternative approaches to health care are established.

- **New Organization of the Ministry of Health.**
  The Ministry of Health, until recently, has been structured on pronounced functional lines – institutional health, community and public health, mental health, emergency and special care, finance and administration, and policy and planning. A new matrix management system has been introduced to enable the Ministry to address issues of the disconnectedness of the functional structure, enabling it to more effectively deal with cross-cutting issues such as cancer, AIDS, women's health and native health.

- **Management Board Review of the Health and Social Service Program Structure.**
  A review of the health and social service program structure of the Ministries of Health, and Community and Social Services is expected to lead to a better coordination and rationalization of their respective programs.

22. Martin Barkin, Deputy Minister of Health, Speech to the Ontario Hospital Association, Toronto, October 18, 1988.

While the factors described above suggest that there may be more scope for implementing recommendations on community services than previously, it would be a mistake to assume that their implementation will now be assured. Examples of steps that could help with such a strategy of capitalizing on these factors include:

- measures to ensure coordination and synthesis of recommendations emerging from the various task forces and review processes underway. This could involve a formally established organizational function within government charged with both the responsibility and authority to oversee change processes;
- steps to ensure that current review initiatives and factors facilitating change take advantage of, and are addressed by, efforts to test innovative approaches to health care delivery. In particular, this should involve explicit measures to use the newly established Health Innovation Fund to capitalize on the factors discussed above; and
- taking measures to ensure that the themes running through the factors above, and the results of the various review processes underway, are very well communicated to the public and groups with an interest in health. This will serve to help them understand the necessity for change and the nature of solutions being proposed.

RECOMMENDED POLICY AND PROGRAMMATIC INITIATIVES

We are recommending several policy and programmatic initiatives to move toward implementing the vision for community services. These initiatives fall into four major categories:

- Organizational;
- Funding;
- Professional Training and Manpower; and
- Information and Support Building.

ORGANIZATIONAL INITIATIVES

These initiatives are intended to address several obstacles identified earlier (in particular, the fragmentation of services and the lack of awareness of community services). They support the definition of community services as being locally responsive and the values proposed for the vision. The fundamental underlying assumption of these organizational initiatives is that responsibility and accountability for planning and managing community services would be at the community level. Specific initiatives include: rationalization and local planning of community services; fostering collaboration and partnerships; enhancing access to community services; and encouraging new sponsors for community services.

- **Rationalization and Local Planning of Community Services:**
  This initiative would encourage individual communities to coordinate the planning, development, management and delivery of community services. It would involve the development of local planning frameworks and needs analyses for developing community services, the rationalization of local services and the development of service linkages and collaboration referral networks among local service providers.

  Specific actionable proposals to implement this initiative are:

  A.1 Encourage a more coordinated approach to planning and funding community services by requiring community service programs in government ministries to report their objectives, target populations and relationships with other programs;

  A.2 Require community agency role studies. Develop guidelines for these studies including details on how to clarify objectives and to determine service needs, service overlaps and duplications;

  A.3 Establish organizational structures and responsibilities to support the administration of local funding envelopes, (see page 24) and;

  A.4 Fund pilot studies carried out jointly by District Health Councils and Social Planning Councils on means for rationalizing community services. Make rationalization studies a condition for introducing local funding envelopes.

- **Partnerships and Collaboration:**
  This initiative would provide support and incentives for the creation of partnerships and collaboration among community services and between institutions and community services. The objectives of this policy direction would be to: reduce overlaps in services provided; minimize problems encountered by consumers in meeting their full range of service needs and reduce the need for consumers to "shop around" in order to obtain the services or mix of services that they require; and improve the continuity of care as patients' care needs change.

  Actionable proposals to support this initiative are:

  A.5 Revise committee structures of District Health Councils so that they are cross sectoral, encouraging collaborative approaches to planning and service delivery;

A.6 Establish arrangements in the Ministry of Health for pooled funding from different program streams. Place priority on funding applications for community/institutional partnerships;

A.7 Identify collaborative ventures (community/institutional) as a funding priority of the Health Innovation Fund;

A.8 Mandate the new matrix coordinators in the Ministry of Health to encourage collaboration. Explore the possibility of providing matrix coordinators with their own service expenditure budgets;

A.9 Fund professional interchange programs between community services and institutions;

A.10 Require evidence of cross sectoral consultation between community and institutional services as a condition for funding new program proposals in individual catchment areas; and

A.11 Establish special arrangements for agencies to retain any portion of budget surpluses attributable to cost-savings achieved through collaboration or the creation of partnerships (as with the Business Oriented New Development (BOND) initiative).

- **Enhancing Access to Community Services:**
There are several dimensions to access: knowledge and information; referral practices; language of service; consideration of unique cultural characteristics; hours of service; availability of services within a reasonable geographic distance; and linkages among various community and institutional services. This initiative would be aimed at increasing the accessibility and attractiveness of community services. Specific actionable proposals include:

A.12 Fund community resource information lines with services in multiple languages that would provide guidance to consumers seeking appropriate services;

A.13 Develop "user friendly" local community service directories for consumers through District Health Councils;

A.14 Change legislation to allow publicly-funded community services to advertise the services they offer;

A.15 Sponsor and evaluate projects for District Health Councils to establish central community service registries to serve discharge planners and other referring professionals; and

A.16 Fund a signage program for publicly-funded community service agencies to parallel the blue and white "H" signs for hospitals.

- **Encouraging New Sponsors for Community Services:**
Two themes which have run through discussions of Ontario's health care system are "responsibility", and "a shared direction". This initiative would lend support to the achievement of these themes by encouraging new and non-traditional sponsorships for individual community services agencies. In particular, efforts would be made to involve business and labour in the funding of new community services. Services could include those involving occupational health; health promotion and illness prevention programs and services; community mental health agencies (e.g. hostels); and primary care services. Specific actionable proposals to implement this strategy are:

A.17 Attach priority to new community services funding proposals which have external sponsorship;

A.18 Encourage District Health Councils to approach potential sponsors in the business, labor and academic communities to sponsor innovative services; and

A.19 Involve business and labour groups in local health care planning committees of District Health Councils.

FUNDING INITIATIVES

Funding initiatives are proposed to address several of the obstacles and issues identified earlier, including: the "add on" treatment of community services; the separation and rigidity of the principal funding streams; and the need to spread responsibility for health and health care. It acknowledges the principle that community services should be locally responsive and directed. Three initiatives are proposed: integration of funding streams; more secure funding of community services; and creation of local funding envelopes:

- **Integration of Funding Streams:**
  This initiative would involve integrating the funding streams for institutional and community services. There are several benefits expected from this arrangement: more coordinated planning of community, hospital and other institutional services; a more useful basis for planning and coordination efforts to ensure that patients receive services in more cost-effective settings; increased interest within the institutional sector in linking with community services; and the development, where cost-effective, of more community services across the province, in areas where gaps exist. Actionable proposals are:

  B.1 Make provision for greater flexibility in the administration of approved program expenditure votes, permitting intersectoral funding, and realization of benefits accruing from intersectoral, inter-program impacts; and

  B.2 Give Ministry matrix coordinators responsibility for establishing and coordinating cross-program spending.

- **More Secure Funding of Community Services:**
  A significant amount of funding for community services provided by the Ministry of Health and the Ministry of Community and Social Services is only provided for short periods of time, leaving many agencies unsure of their futures. The insecurity of program funding can inhibit agencies' capacity to attract the best professional staff and can contribute to clients' lack of confidence in community services. New funding policies would involve providing longer term core funding for community services. Actionable proposals include:

  B.3 Require a commitment from the Ministries of Health and Community and Social Services to provide more long term funding of community services. Require a review of funding programs to identify opportunities to shift community services to longer term funding arrangements;

  B.4 Conduct a review of program funding streams involving short term funding with a view to defining what should be shifted to long term funding; and

  B.5 Place priority on providing long term funding to health promotion and illness prevention services. In the short term, require that a specific proportion of the provincial health budget is dedicated to promotion and prevention activities.

- **Local Funding Envelopes:**
  This strategy would involve the creation of local health service funding envelopes for both community and institutional services. Under such an arrangement, a community body independent of the institutional sector would be responsible for determining how local resources are allocated among all services/service providers. Several levels of

envelopes might be considered: regional envelopes might be established with direct responsibility for allocating funds for tertiary care services; and sub-envelopes could be used at a more local level for primary and secondary care and for health promotion and illness prevention services. Specific actionable proposals include:

B.6 Initiate a study through the Premier's Council on alternative administrative mechanisms for regional funding envelopes; and

B.7 Establish and evaluate local pilots to test and refine alternative approaches to local funding envelopes.

PROFESSIONAL TRAINING AND MANPOWER INITIATIVES

Three initiatives are proposed with respect to professional training and manpower planning. These initiatives are intended to address the obstacles of professional attitudes towards practicing in community services, the dearth of professionals equipped to practice in community services and providers' lack of knowledge as to how to take full advantage of community resources. Specific initiatives include: creating attractive career opportunities in community services; a joint approach to manpower planning and development; and enhancing the training of health professionals in community services.

- **Creation of Attractive Professional Career Opportunities in Community Services:**
  This initiative would be aimed at attracting more professionals to community services, including physicians, nurses, rehabilitation therapists, counsellors and social workers. It would involve the reduction of any financial barriers to employment in community services (e.g. providing wages to nurses in community services which are equitable with those in institutions, providing premiums to physicians who practice in community services and offering more financially secure employment) and improving the services and facilities available to professionals who work and practice in community services. Specific actionable proposals include:

  C.1 Introduce incentives into the OHIP fee schedule to attract individuals to practice in non-hospital services;

  C.2 Introduce financial incentives and flexible approaches to employment (e.g. job sharing) to attract nurses and other professionals to work in community services; and

  C.3 Make funding available to provide professionals practicing in community settings with resources necessary to support their practices (e.g. equipment, data bases, diagnostic support, communications).

- **Joint Professional/Government Manpower Planning:**
  Under this implementation strategy, the government would take a more active role in manpower planning and deployment decisions. Joint government/professional bodies would be established to decide upon: provincial health professions resource needs; their deployment across the province; and means for ensuring adequate supplies of health professionals to work in community services.

  The Subcommittee plans to address this issue at a later point. In the meantime, consideration might be given to:

  - providing incentives to encourage physicians and other health professionals to establish practices in community settings;
  - placing greater priority on the training of those types of health professionals in greatest demand in community settings; and

- monitoring the practice location patterns of professionals graduating from various medical, nursing and health professional schools, and targeting those schools with less successful records in community placement for changes to their curricula.

- **Requirements to Educate Health Professionals to Practice in Community Settings:**
This initiative would involve developing incentives and penalties to ensure that health professionals receive appropriate training to equip them to practice in community settings. Elements of this strategy would comprise: requirements to include community service experience as an integral part of professional training; and designating Community Health Centres, Home Care Programs and other community agencies as teaching centres.

Participants in such an implementation strategy could include professional organizations, the Ministry of Colleges and Universities, and professional education and training institutions. Specific actionable proposals include:

C.4 Under the direction of a joint committee consisting of representatives from the Ministry of Health, Ministry of Colleges and Universities, representatives of professional and training organizations:

- set requirements for each Health Science Centre to establish formal teaching linkages with community services;
- develop mandatory requirements for practicums, internships, etc. in community services;
- require changes to curricula for teaching health professionals to enhance coverage of community services including increased attention to promotion and prevention;
- require recruitment of appropriate faculty to teach community practices.

This committee would have responsibility for monitoring actions taken and compliance with the above initiatives.

C.5 Introduce a requirement that additional funding to educational institutions will be dependent upon their compliance with requirements to enhance community services teaching; and

C.6 Sponsor job fairs for community services employment for health professionals and students thinking of following training programs for health professions.

INFORMATION AND SUPPORT BUILDING

This set of initiatives is aimed at increasing public support for, and use of, community services and is intended to address the obstacles of public complacency, lack of awareness of community services and lack of recognition of the contribution of community services. The individual initiatives proposed are:

- **Marketing and Information on Community Services:**
A marketing and information program for community services would be aimed at consumers, educators, and health care professionals. This initiative would be undertaken to:

- provide comprehensive and easily understandable information to individuals on the choices available to them in meeting their health needs; and
- overcome some of the stigma of community services (e.g. "they are for the low income groups only", or "only those health professionals who cannot make it in private practice or hospitals work in community services", or "community services force things on me, as a consumer, that I do not want", or "service providers in the

community services sector are left-wing radicals", or "health professionals cannot make a decent living or practice state-of-the-art care in the community sector").

Specific actionable proposals include:

D.1 Provide funding for information and advertising campaigns about the range of services offered by individual community services;

D.2 Sponsor a media campaign to improve the image and levels of awareness of community services; and

D.3 Sponsor a parallel image and awareness campaign through health professions' associations and training institutions.

- **Heighten Public Awareness of Current and Impending Problems in the Province's Health Care Delivery:**
  This implementation strategy would be aimed at increasing public awareness of current and impending problems confronting health care delivery in Ontario. The objective of this strategy would be to create a climate conducive to change in health care delivery by:

  - heightening public awareness of the pressures confronting the system and achieving support for introducing changes to health care delivery; and
  - enhancing political will to introduce and see through changes which may be contentious for some key interest groups.

  Information would be provided on: the costs and resource implications of current delivery approaches; the limits to patient benefits associated with some particularly costly health care practices; and possible alternatives for addressing current and impending problems.

Specific actionable proposals include:

D.4 Fund District Health Council's to sponsor educational and media forums on current pressures facing health care delivery;

D.5 Provide information to consumers annually on the costs of services they have received;

D.6 Prepare reports for popular consumption on pressures on the health care system;

D.7 Sponsor broadcast media productions for the main T.V./Radio stations and for T.V. Ontario on the health care system, its costs and outcomes;

D.8 Carry out an information campaign through hydro and other widely received utility bills on health costs, opportunity costs and trade-offs associated with various health care practices; and

D.9 Monitor public attitudes on the state of health care delivery.

- **Fostering the Development of a Strong, Organized Voice for Community Services:**
  The allocation of health care resources has historically been subject to external lobbying campaigns by well organized interest groups, particularly of the dominant physicians and hospitals. Community services have not been organized in an equally strong or cohesive fashion. This initiative would involve providing seed money for the creation of a community services association. We identify one actionable proposal here:

D.10 Sponsor a conference to help community agencies develop mechanisims for ensuring their representation in public policy discussion.

- **Support for Community Services Research and Evaluative Studies:**
  This initiative would involve an increase in resources devoted to research on community services and their delivery. Priority would be given to research carried out jointly by providers and academics and on innovative studies. In addition, funds would be made available for evaluative research. This initiative would be aimed at increasing the interest in community services by health care researchers and professionals and would contribute to establishing an empirical basis for measuring the impacts and cost-effectiveness of community services. Specific actionable proposals include:

  D.11 Earmark 50% of funds within the Health Innovative Fund for community services projects and evaluations;

  D.12 Set in motion a comprehensive plan for the systematic evaluation of the cost-effectiveness of existing provincial government community service programs. Evaluations would address the cost-effectiveness of individual community services, the systems impacts of community services and their relative success in addressing community health needs; and

  D.13 Establish an Office for Community Services Assessment with ongoing responsibility for identifying what does and does not work in community services.

THE EXPERT PANEL

A key part of this study process was a two-day conference held with a panel of invited experts including service providers, administrators, government officials, academics and consumers (a full list of participants is provided in Appendix C of this report). The purpose of the panel was to test, challenge and refine some of the preliminary conclusions of this study. The format involved circulation of a discussion paper in advance of the conference, a few keynote presentations and discussions using the discussion paper as a point of departure. These discussions included three breakout groups of 12 to 15 participants and plenary discussions of all conference participants.

The discussions addressed the study premises: the definition of community services; the vision; current problems; the desired directions; and implementation obstacles. They also included consideration of the specific proposals reflected in the previous section of this report. For the sake of structuring the conference proceedings, these proposals were broken out into three headings: funding; education and manpower; and information communication and support building. The key themes and conclusions of these proceedings are summarized in the remainder of this section.

Underlying premises

The discussions on the study premises were vigorous and very wide ranging. They showed a degree of uncertainty as to the definition and rationale for community services used in the initial discussion paper. Some participants saw the community services thrust as a move towards integration of institutional and community services and talked about an expanded role for hospitals reaching out further into the community. Others argued that community services should entail a totally different orientation from the institutional sector focusing on maintenance, promotion and prevention and should seek a different health paradigm, relying on new non-traditional types of professionals. Others stressed the notion of community development. The overriding conclusion to emerge from these discussions was the **need to have a clear definition of community services, a clear rationale, and a clear understanding of the defects in the current system that strengthened community services are intended to remedy.**

Specific points made in this discussion of the premises for the study included:

- the need to address the compartmentalization of care. Individuals' care needs and health problems do not fall into neat compartments corresponding with those of the current health care system;
- the need to convince the public of the urgency for system change. A strong message is needed to unsettle public complacency. A parallel was drawn with the environmental movement. A counterpoint was articulated that there was a danger of creating an artificial crisis. Another participant felt that the public is not complacent, that they are currently struggling through major barriers to access services, and that the services they are getting are inadequate;
- community services should be recognized as the main source of primary care. Reference was made to proposals for health care delivery in Australia;
- it was argued that the case for shifting emphasis to community services should be premised on the lack of resources and institutional capacity to deal with future demand for services. Another participant noted that, while cost might be a major motive for emphasizing community services, we should be prepared to invest more money in them up-front. It was pointed out that no private industry would change product-lines without making substantial investments in retooling and marketing;
- one participant cautioned against setting the institution up as the norm which needed to change. Rather the focus should be on community services existing in their own right, and enabling them to co-exist in a state

of friendly competition with the institutional sector. It was also argued that emphasis on coordination and integration would result in cumbersome and expensive organizational structures;

- another point of view held that hospital services should be seen as part of the community sector and that this was the case not only for smaller general hospitals but also for large parts of tertiary care hospitals;
- the importance of having a clearly articulated ideal model for community services was stressed. In the absence of such an ideal model, one runs the risk of simply having a lot of uncoordinated and incoherent service activity in the community sector. It was also pointed out that there was a need for overriding or guiding principles to assist funding decisions;
- several participants pointed out that discussion of directions for community services could not be separated from organizational issues;
- several participants stressed the role that community services should play in health promotion, prevention and health maintenance;
- the point was made that because Ontario's health care system is characterized by a single payor (government), there is a tendency to inhibit local variation, experimentation and innovation. We should place more emphasis on doing pilots. On the other hand, the single payor system affords the opportunity to make great across-the-board changes in a manner that would be unimaginable in the U.S.;
- one participant felt that more attention should be given to technologies needed to support community services;
- several participants stressed the importance of organizing community services around the needs of individuals. The notion of consumer responsibility and accountability was emphasized. The importance of not letting community agencies become driven by provider self-interests was also a strongly voiced theme;
- a consumer representative emphasized the need for consumer information to better facilitate access to the appropriate services.

Information Communication and Support Building

The expert panel pointed out the necessity of having a well articulated focus to communication and support building efforts. These efforts should be based on a clear understanding of what community services represent, why they are being promoted, whom they are being promoted to, what the communication efforts are intended to achieve and how they are meant to do that. The panel generally supported the actionable proposals put forward in the discussion paper. Specific comments regarding these proposals and additional suggestions for proposals included:

- some concerns were expressed over the proposal for annual health statements for consumers on the basis of privacy issues and concerns about the likely accuracy of individual cost data. However, it was pointed out that Alberta had already adopted such an approach. Public hearings of the Premier's Commission on Future Health Care for Albertans indicate a high degree of public interest in these statements;
- it was felt that in addition to T.V. Ontario productions on issues in health care, documentaries should be commissioned for commercial stations, thereby reaching a much broader audience;
- concerns were raised about providing seed money for the development of a community services association, although there was support for encouraging a unified voice for the community services sector;
- additional suggestions for actionable proposals included:
  - telephone information services to put consumers in touch with appropriate service providers;
  - making the telephone book more helpful to consumers searching for a health care provider; and

- kiosks set up in malls and public buildings to provide consumers with health care information.

- the need for public information campaigns on issues in health care was recognized. It was the view of some panel members that most members of the public believe that the answer to current problems in health care includes more hospital beds, more doctors and greater use of technology.

Funding

The breakout group discussing funding strategies supported the notion of achieving a shift in funds from the institutional to the community sector. It was suggested that targets be established for the proportion of the provincial health budget to be devoted to community services by a given date. In addition, it was suggested that a certain proportion of funds should be earmarked for health promotion and prevention. It was felt that some funding for promotion could come from non-governmental sources such as employers. The mandates of certain providers should be broadened to include promotion and prevention.

The panel generally supported the actionable proposals regarding funding strategies. Additional suggestions included:

- fifty percent of the Health Innovation Fund's dollars should be earmarked for community services. The fund should also give priority to proposals which emphasize collaboration and mergers among community-based programs;
- there was broad support for the notion of funding envelopes and the panel recommended the introduction of at least one pilot scheme by 1991 to test the approach;
- the breakout group felt that the "actionable proposals" should be more action-oriented with fewer recommendations for studies and more actual implementation of proposals;
- the breakout group also saw a need for a high level, inter-ministerial group to oversee the implementation of the actionable proposals;
- an additional actionable proposal was suggested to ensure more competitive remuneration of professionals working in community settings. It was also suggested that the Ontario Health Insurance Plan fee schedule should be adjusted to achieve greater incentives to provide non-hospital services;
- it was argued that funding incentives to shift emphasis from institutions to the community should involve both penalties and rewards.

Health Professional Training and Manpower

The breakout group on training and manpower argued that the needs of the health system must drive who is trained and how. Thus, it is important at the outset of this kind of planning to have a clear sense of the system people are being trained for. Training efforts should cover not only service providers, but also planners and administrators. It was also pointed out that initial training for professionals has to be supported by continuing education for those already in practice.

It was argued that if the primary objective of a community services policy is to realize a more cost-effective health care system, it would not be appropriate to simply move existing manpower from institutional to community settings. Doing so would not change the resource inputs that determine the overall cost of the system. Some of the panel argued that a new type of community services professional is required who would be prepared specifically for work in community agencies. They should be trained to make effective use of the whole health care system on behalf of their clients. It was also argued that there should be a systematic program of inservice training for individuals in key positions involving interfaces between components of the health care system, including discharge planners, board members and journalists.

Specific comments on, and changes to, the actionable proposals that were discussed included:

- the need to broaden the curricula for health professional training to include: prevention, promotion, politics of health care, health policy, organization of care and the limits to institutional care;
- health providers need to learn more about community service providers that they could be referring to;
- one panel member pointed out that professional education has recently gone through considerable change to ensure greater exposure to community practice;
- it was also suggested that efforts to increase awareness of the opportunities for health professionals to practice in the community should start early and should be directed at high school students who might be considering a career in a health profession; and
- one breakout group member felt that the most fundamental problem was the "poor cousin" status of community services. Jobs in community services pay less. Community medicine academics tend to be paid less. As a result, the field attracts second-rate students and second-rate teachers.

OPTIONS AND CONCLUSIONS

In this section, we review the options and choices that have been implicit in the various stages of this study and assess once more the course we recommend. This includes choices regarding the basic premises: the rationale for emphasizing community services; the scope of community services; their role; and who they should serve. We also review the four main types of strategies: organization; funding; training; and support building. In each, we consider the possible alternatives.

The Premises

There are numerous potential *rationales* for community services:

- seeking a cost-effective alternative to institutional care;
- preference for care provided in a home or community setting rather than in an institutional or inpatient setting;
- recognition that community services have an important contribution to make to health, independent of their relationship with institutional care; and
- concern about over emphasis on treatment rather than health promotion, prevention and maintenance.

We found various of these rationales reflected both in previous reports on community services and in discussions of the Subcommittee and the Expert Panel. Upon consideration, we adopted a blend of these rationales. We noted the danger in adopting simplistic cost-effective "alternatives to institutions" rationale. It was clear that community services were desirable for other reasons, some of which supercede questions of short-term cost, reasons such as quality of life, personal preference and concerns for promotion and prevention.

Another premise issue that the study had to address was the *structural relationship between the community services sector and the institutional sector*. The choices fell between the two extremes of total amalgamation/integration of the two sectors and maintaining them in an arms length relationship. We recognized the importance of linkages and collaborative arrangements between the two sectors to ensure continuity of care. However, we also saw dangers in encouraging comprehensive integration:

- the danger that institutional interests will dominate over community service interests, with the institutions using community services as a means of capturing patients and a means of sustaining organizational growth in a period of deemphasis of institutional care;
- the danger that institutions would fail to respond to those community needs that do not overlap with institutional needs, recognizing that the congruence between community service populations and institutional populations is far from total; and
- the danger that any new expanded organizations spanning both institutional and community services are likely to be even more monolithic than existing institutions and more predisposed to problems in terms of responsiveness to community needs, productivity, cost control and accountability.

We, therefore, favour a relationship that is characterized by friendly and, where appropriate, collaborative competition between the two sectors. We recognize that, on this point, there was not unanimity on this among the members of the Subcommittee, the Expert Panel nor among the previous reports. However, in light of the arguments made above, we caution against any drive for comprehensive integration.

A third premise issue raised in this study is the question of the *scope of community services* in relation to the traditional differentiation between primary, secondary and tertiary care. Clearly, community services have a fundamental and leading role to play in primary care. However, we do not see the role of community services as being limited to primary care. As technology makes it increasingly possible to

perform surgery on an ambulatory basis, and to provide other hospital replacement services such as advanced homecare services, attempts to constrain the scope of community services to primary care appear contrived.

A fourth premise question raised in the course of this study is that of *who should be served by community services*. There has been a tendency in the past to associate community services with radical health care, and health care for disadvantaged groups. We recognize that community services can make a special contribution in reaching disadvantaged groups, but we also believe that part of the failure of previous task forces and review processes has been their lack of success in gaining broad acceptance for the notion of community services as mainstream health care.

Organizational Strategies

The study noted the fragmented nature of the community services sector and some of the problems arising from a rigidly compartmentalized funding system. Looking to the future, there are several organizational options:

- continue with the status quo;
- decentralize the governance, planning and/or management to a regional or district level permitting more flexible local approaches to program organization;
- place greater emphasis on flexible funding and flexible structuring of services within the context of centralized administration and funding. This approach could entail greater reliance on the matrix elements within the Ministry of Health to address needs that cut across traditional funding lines and through more flexibility with joint Ministry of Health and Ministry of Community and Social Services service initiatives.

This question of organizational structure has only been dealt with tangentially in this study. It is given more attention in the parallel Study on Funding and Incentives. However, given the problems identified, and the emphasis on accountability to the community, responsiveness and equity, this study clearly signals the need to explore alternatives. In the spirit of previous reports, such as the Ontario Health Review Panel which stressed pluralistic solutions, we recommend further exploration of the decentralized models through conducting several pilots. In the meantime, efforts have to be made to introduce greater flexibility within the context of existing centrally administered programming.

Funding Strategies

Many of the actionable proposals presented in section 9 involved reliance on funding to provide the motivation for achieving desired action in such areas as: access to community services; collaboration; rationalization of services; regional administration; and research on community services. Clearly, funding represents an important instrument that can be brought to bear to achieve change.

When we examine the predominant funding structures we find that the main options parallel those for organization:

- reliance on existing funding arrangements that are generally defined by established Ministry funding streams;
- more flexible approaches to Ministry funding through greater reliance on the cross-cutting matrix elements of the new Ministry of Health organization; and
- local and regional funding envelopes.

The recommendations from this report lean strongly toward introducing a greater degree of flexibility to existing arrangements while also testing and exploring options for local funding envelopes.

Training Strategies

Strategies involving preparation of manpower were seen as key to ensuring the effective implementation of measures to strengthen community services. Options for training strategies included:

- the status quo in which many professional groups lack appropriate preparation to either work in the community sector or to make effective use of community services;
- focussed efforts to introduce programs for both practicing professionals and those in training in professional schools to prepare for both work in the community services sector and taking better advantage of the health care resources available in the community sector; and
- undertake a fundamental reform of the types of health professionals working in the community sector and introduce new types of professionals prepared specifically for work in community services.

The study concludes that the training and preparation of health professionals should be driven by the manpower needs of the current and future health system. Clearly, the status quo option would not serve the directions outlined in this report. We strongly favour the second option and see initial training and continuing education as fundamental to achieving the direction outlined in this study. We hold judgement on the third option, with the hope that the manpower preparation needs of the health care system will be addressed by the second option. We fear that introduction of new professional categories may only create additional confusion and fragmentation of the health system.

Support building and information strategies

We argue that the support building and information strategies put forward in this report will be fundamental to the success of proposals from the report as a whole. They will contribute to political will and good planning in the implementation process. We see no significant options in this area. Failure to build support and provide appropriate information to the public and providers could result in this Premier's Council initiative simply joining the list of other review processes that, for the most part, failed to be translated into action.

IMPLEMENTATION FRAMEWORK

Implementation is the Achilles' heel of realizing the vision for a stronger, more responsive and effective community services sector. We attribute the failure of past recommendations, in large part, to shortcomings in implementation. In this context, we recommend well- defined accountability structures and processes for implementation.

We recommend the establishment by the Premier's Council of a Community Services Implementation Secretariat. This body would be charged with overseeing the implementation of the initiatives and actionable proposals put forward in this report. It would develop detailed implementation plans for each actionable proposal in consultation with the Ministries and other agencies responsible for their implementation. It would coordinate and monitor implementation, and report implementation progress to Council on a twice yearly basis. It would sponsor evaluation studies jointly with the groups responsible for specific initiatives/actionable proposals. All the actionable proposals put forward in this report should be subject to evaluation as part of the implementation process. Evaluation results should be reported to Council.

We recognize that the directions outlined in this study represent a substantial shift for the province's health care system. Clearly, their implementation has to be planned carefully. This will include assessment of impacts and implications for other providers and for consumers; consultation with agencies responsible for providing services; information on and promotion of new initiatives; linkages with other services; and articulating and communicating objectives to the public, service providers and community agencies.

APPENDIX A: TERMS OF REFERENCE

COMMUNITY SERVICES STUDY

INTRODUCTION

The Premier's Council on Health Strategy was established, in late 1987, to provide advice to the Premier and the government on the future directions for health and health care in Ontario.

To assist the Council in carrying out its mandate, four subcommittees have been established. The Health Care System Subcommittee has identified community services as a key issue as a result of a review of three major reports: Evans, Spasoff and Podborski.

STUDY OBJECTIVES

The government's social policy field and the Ministry of Health in particular have identified the development of the community services sector as a strategic area for growth and development. Many initiatives have been implemented to strengthen and support this movement. Health care research, specifically the Evans and Spasoff reports, note the importance of developing linkages among the parts of the system while achieving a more integrated and comprehensive network of community based services.

The Health Care System Subcommittee supports the objective of strengthening the community based service network. In doing so, the committee wishes to *investigate the options available and issues involved* in recommending developmental strategies to accomplish this objective.

ASSIGNMENT

The Subcommittee is seeking assistance in developing its recommended approach for the future development of community based services in Ontario. In developing its recommendations the committee requires a sound knowledge base of the existing structures, options to be considered, implementation issues to be considered and an understanding of the lessons to be learned from other comparable jurisdictions.

What currently exists?

- Based on the information available from Ontario government ministries and other relevant sources, prepare a synthesis of the types of both public and private community based health and health related services (a detailed inventory is not required).

NOTE: The Ministries of Health and Community and Social Services have much of this information on file.

- By type of service, indicate the nature of the services provided, delivery agent, funding source, client groups and program expenditures.
- Indicate the relationship and linkages to related inpatient or community services.
- Provide an analysis of the costs and benefits.

What are the key issues?

- What are the key considerations in attempting to shift resources and services to community based care models?
- What general lessons can be learned from other comparable jurisdictions?
- What are the barriers to and incentives required for improving the community service network in Ontario?
- What are the impacts on the current system:
  * manpower
  * financial
  * potential disruptions
  * potential benefits

What are the options to be considered for orderly implementation of an enhanced community service network?

- Describe the primary strategies for implementation?
- Analyze the strategies for benefits and pitfalls?
- Analyze the cost implications for each strategy.
- Outline lessons to be considered from successful or unsuccessful implementation in other comparable jurisdictions.

APPENDIX B: INVENTORY OF COMMUNITY SERVICE TYPES

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PROFESSIONAL HOME HEALTH (TREATMENT, REHABILITATION, MAINTENANCE)

Target Clients

- Elderly individuals with chronic disabilities/ illnesses/ conditions.
- Individuals receiving palliative care.
- Individuals who have been discharged from hospitals with acute care requirements for nursing and other professional services.
- Physically disabled individuals.

Objectives

- Avoid or delay the need for institutional admission.
- Facilitate earlier discharges from institutions.
- Reduce lengths of institutional stays.
- Improve the quality of life of individuals in palliative stages of illness.

Range of Services Offered

- Visiting nursing care, psysiotherapy, occupational therapy, speech therapy, nutritional services, social work, drugs, dressings and medical supplies, diagnostic and laboratory services, hospital and sick room equipment are made available to individuals in their homes.

Local Delivery Management

- Management of local service delivery of publicly-funded home health services is by local Boards of Health, some hospitals, not-for-profit nursing agencies (e.g. VON, St. Elizabeth's), regional social services departments.
- Privately funded services are managed by providers (e.g. not-for-profit providers, commercial nursing agencies, for-profit nursing homes).

Funding Sources

- Funding of publicly supported (insured) professional home health services is provided through the Home Care Program and the Ministry of Health under the Ontario Health Insurance Act.
- Services not insured under OHIP can be funded directly through payment by the client or through private insurance premiums.

Provider/Delivery Arrangements

- Direct services to consumers are provided by not-for-profit, voluntary and commercial agencies (e.g. VON).
- Case management services to individuals who qualify for provincially insured services are the responsibility of 38 local home care programs across the province. Case managers assess eligibility, develop plans of care and order services from service providers. They are also responsible for periodic reassessments of individual cases.

Linkages With Other Services

- Homemaking/home support services.
- Physician services.
- Hospital services (generally excluding ambulatory care).
- Chronic care facilities.
- Children's treatment centres/health services to children in schools.
- Public health.

HOME SUPPORT SERVICES (SOCIAL SUPPORT, PERSONAL CARE)

Target Clients

- Elderly individuals.
- Disabled individuals.
- Individuals convalescing.
- Individuals with chronic health care needs.

Objectives

- Substitute homemaking services for care in institutions thereby enabling deinstitutionalization.
- Divert persons eligible for an institution from being institutionalized.
- Prevent premature or inappropriate institutionalization by maximizing person's ability to manage in a home setting.

Range of Services Offered
- Assessment.
- Home help (e.g. marketing, cleaning, meal preparation).
- Personal care (e.g. attendant care).
- Meals delivered.
- Friendly visiting.

Local Delivery Management
- For publicly funded services, local delivery management is assumed by local home care administering agencies (e.g. Boards of Health, VON, hospitals, regional social services departments).

Funding Sources
- Ministry of Community and Social Services (Integrated Homemaker Program).
- Municipal governments (Homemaker and Nursing Services Act Programs).
- Veterans Affairs Canada.
- Voluntary organizations.
- Service clubs.

Provider/Delivery Arrangements
- Services to clients are provided directly by not-for-profit and commercial agencies and community volunteers.
- For individuals who qualify for homemaking services funded by MCSS, Home Care case managers determine eligibility, assess need, order services and re-evaluate needs.

Linkages With Other Services
- Closely related to professional home health services.
- Institutional care (particularly chronic).

COMMUNITY MENTAL HEALTH

Target Clients
- Individuals with psychiatric disabilities including individuals discharged from psychiatric hospitals.

Objectives
- Help maintain individuals with psychiatric disabilities in a community environment.
- Avoid hospital admission or readmission, where possible.

Range of Services/Service Settings
- A range of services is available in a variety of settings.
- Services include:
  - acute treatment (in-patient) generally provided in community general hospitals with psychiatric units;
  - other treatment and clinical services such as counselling and crisis intervention;
  - out-patient services;
  - day care services;
  - supportive housing (transient, emergency, long term, halfway houses, hostels, group homes);
  - vocational and social rehabilitation;
  - self help and voluntary services; and
  - addiction services (assessment, and referral, day programs, counselling, case management, residential).

Local Delivery Management
- A variety of organizations including 10 provincial psychiatric hospitals, 396 community-based mental health and addiction services and 64 general hospital psychiatric units, community health centres, churches and public health units. There is a proliferation of community boards which operate the 396 noted community-based services. In some areas, umbrella organizations have been established to manage and coordinate new programs. District Health Councils receive, review and rank proposals for community mental and addiction programs. Each of the 10 psychiatric hospitals have established Community Advisory Boards which are involved in the identification of and planning for responses to local needs.

Funding Sources
- The majority of services are funded by the Provincial government, primarily the Ministries of Health and Community and Social Services on a budget funding basis.

- Municipal governments also fund certain services (e.g. hostels).

Delivery Arrangements
- A variety of organizations are involved in local service delivery, depending on the service type.

Linkages
- Rehabilitation services.
- Professional home health services.
- There are also linkages among the various agencies and institutions which deliver community mental health programs and services.

DAY CARE SERVICES

Target Clients
- Cognitively impaired, moderately confused individuals.
- Elderly individuals who wish to and are able to remain safely in their homes, but require minimal attendant or support services, social activity and friendship.
- Adults with mental health needs (see community mental health).
- Children with physical and/or psychological problems and/or social, emotional disturbances.

Objectives
- To enable individuals who require social/physical/psychological support services to live safely or securely in their home environments.
- To improve the quality of life of individuals who would otherwise be left alone during the daytime.

Range of Services
- Assessment services.
- Social support.
- Recreational programs.
- Treatment (e.g. medical, nursing, therapies).
- Various services which will prepare individuals for independent living.
- Assessment with education/preparation for independent living and adjustment to pressures of urban life.
- Services are offered in a variety of settings:
  - Homes for the Aged;
  - Elderly Persons Centre run by municipalities and non-profit corporations;
  - Children's Mental Health Centres (outpatient, day programs, summer camps);
  - community general hospitals;
  - psychiatric hospitals; and
  - stand alone facilities.

Local Delivery Management
- By organizations as noted under "Range of Services".

Funding Sources
- Ministry of Community and Social Services.
- Ministry of Health.

Delivery
- A variety of delivery arrangements is involved, depending on the service setting.

Linkages
- Community health providers.
- See Range of Services.
- Physicians.
- Respite care.

REHABILITATION SERVICES (EXCLUDING COMMUNITY MENTAL HEALTH SERVICES)

Target Clients
- Individuals with developmental handicaps.
- Individuals with physical disabilities.
- Individuals recovering from acute illness episodes (e.g. strokes).

Objectives
- Enable individuals to adapt to an impairment, restore or improve physical, emotional, social, vocational, functional level.

Services Provided

- Services are provided by a variety of professionals including medical, occupational therapy, physiotherapy, speech pathology, social workers, rehabilitation nurses, psychiatrists, psychologists, biomedical engineers, including:
  - special education in elementary and secondary schools (e.g. programs for trainable retarded, special education funding for hearing impaired and blind);
  - financial assistance for assistive devices which could allow individuals a better qualify of life in the community;
  - out-patient speech pathology and audiology programs in 89 hospitals;
  - other out-patient rehabilitation programs in hospitals;
  - identification, assessment and diagnostic services;
  - counselling and referral;
  - group homes for developmentally handicapped;
  - lifeskills necessary to community living and independence in group homes, workshops, community colleges, hospitals, family counselling agencies; and
  - halfway houses and group homes for alcohol and drug abusers.

- Developmental services.
- Vocational rehabilitation services (e.g. in sheltered workshops) and employment-related services (advice and referrals) to disabled individuals.
- Various housing-related assistance for disabled persons (e.g. linkages between disabled persons and housing suppliers with appropriate units available, and grants for physically adapting housing to make accessible for disabled persons).
- Advocacy.

Local Delivery Management

- A variety of organizations is involved including agencies which administer local Home Care programs, Children's Treatment Centres, March of Dimes, Goodwill and community colleges.

Funding Sources

- Funding is provided by a wide variety of government and non-government organizations.
- Provincial government funding is provided by the Ministry of Community and Social Services, the Ministry of Education, the Ministry of Housing and the Ministry of Health (Institutional Branch, Home Care Program, Assistive Devices Program), Ministry of Labour.

Delivery Arrangements

- A variety of delivery arrangements is involved depending on the services used and the service providers/sponsors involved.
- For educational services, grants and funding are provided by the Ministry of Education for service delivery in elementary and secondary schools.
- Municipal hostels are frequently delivered by churches.
- Sheltered workshops are delivered by groups such as the March of Dimes and Goodwill.
- Special services (e.g. adaptation of housing) are provided for by the grants to individuals.
- Lifeskills are delivered by community colleges, hospitals, family counselling agencies, group homes, sheltered workshops.
- Various therapy and other professional rehabilitation services are delivered in out-patient departments of hospitals and Children's Treatment Centres.

Linkages With Other Services

- Professional home health.
- Physicians.
- Institutions.

RESPITE SERVICES

Target Clients

- Elderly persons.
- Physically or mentally incapacitated individuals requiring constant or intermittent care.
- Caregivers (family members or significant others) providing care to dependent relatives on a close to 24 hour basis (e.g. those who care for family members with Alzheimer's

Disease or other psychogeriatric problems, children who need assistance and support to live in the community).

Objectives

- Provide relief to caregivers, thereby preventing potential collapse of the home support system.
- Allow individuals to remain in the community, thereby avoiding or delaying institutionalization.

Services Offered

- Short term or temporary institutional care to disabled individuals. Usually planned, but sometimes offered on an emergency basis. Generally provided in a nursing home or continuing care hospital. Can be offered for a few hours at a time or for several days or weeks on an intermittent basis.
- Services include social activities, meals, bathing, hairdressing, some medical services, depending on the setting.
- Provides medical screening and services to those participants who rarely see a doctor in the community.
- Pharmaceutical advice and participant/family counselling.
- Assessment of crisis situations and expediting permanent placement in institutions when necessary.
- Educate principle caregivers on care and management strategies.
- Service settings include:
  - acute care hospitals;
  - chronic hospitals;
  - homes for the aged;
  - nursing homes;
  - retirement homes;
  - residential homes;
  - foster homes;
  - in the home (i.e. by companions/sitters);
  - churches; and
  - seniors' centres.

Local Delivery Management

- Some respite services (e.g., homemaking) are managed locally by Home Care Programs.

Funding Sources

- Ministry of Health.
- Client fees.
- Voluntary groups.

Provider/Delivery Arrangements

- Varies depending on service settings (See Services Offered).

Linkages

- Professional home health.
- Institutional health services.
- Voluntary, self-help groups.

AMBULATORY SERVICES

Target Clients

- Individuals requiring episodic treatment.
- Individuals discharged from institutionally-based treatment centres that need follow-up care.
- Individuals requiring a range of primarily clinical services, that need not be delivered on an inpatient basis.

Objectives

- To avoid or delay institutional admission.
- To facilitate early discharge and reduce length of institutional stays and offer cost effective care.

Services Offered

- Treatment for episodic illnesses.
- Periodic professional care with an emphasis on prevention.
- Immediate access to inpatient care.
- Specialized care suggested on referral basis for particular treatment.
- Service Settings include:
  - solo practice family physician, etc;
  - hospitals;
  - Community Health Centres;
  - Health Service Organizations;
  - geographic full-time physicians (visiting physicians practicing in a hospital setting); and
  - walk-in medical clinics.

Central premise of ambulatory care services is that services are provided without previously booked appointments.

Local Delivery Management
- Community Hospitals.
- Solo/group practices.
- Not-for-profit publically funded agencies.

Funding Sources
- Ministry of Health.
  - private insurance programs eg. Workers Compensation; and
  - some direct billing to client.

Provider/Delivery Arrangements
- Treatment provided in hospitals and clinics which are funded by the Ministry of Health.

Linkages with Other Services
- Community based health and social service providers, home health services, social support groups.
- Acute care facilities.

PRIMARY CARE

Target Clients
- All individuals seeking continuous care with an emphasis on preventative medicine or the same individuals seeking referral to a specialized service.

Objectives
- To avoid or delay institutional admission.
- To provide timely medical/social care.
- To provide an assessment of health needs and possible referrals to special treatment services or programs.
- To act as a gatekeeper or point of entry to the health care system.

Range of Services
- Provides medical advice and some counselling on health related issues.
- Provides a general health assessment:
  - provides a referral to more specialized health professionals.
  - oriented to family practice and general medicine.
- Service Settings include:
  - solo practice family physician;
  - group practice family physicians; and
  - family practice units (affiliated with teaching hospitals).
- Community Health Centres - Health Service Organizations.

Primary care services operate exclusively on an appointment basis. There is provision for consultation which usually involves the client and family members.

Local Delivery Management
- Solo/group practice.
- Satellites of publically funded hospitals.
- Not-for-profit, publicly funded health agencies.

Funding Sources
- Ministry of Health.
- Health Service Organization: funded on a capitation basis.

Provider/Delivery Arrangements
- Services offerings and service setting in Range of Services.

Linkages with Other Services
- Linkages provided to ambulatory health care services.
- Linkages to social services and social support programs.

PALLIATIVE CARE

Targets Clients
- Individuals with chronic or terminal illness/ disease.
- Individuals with chronic disabilities whose condition is not expected to improve.

Objectives
- Optimizing individual's quality of life and minimizing pain and suffering.
- Ensure that terminally ill patients are identified and have treatment protocol established on a timely basis.

- Assist caregivers with the grieving and acceptance process.

Range of Services
- Nursing care.
- Pain management services.
- Social worker services, recreational therapists.
- Pastoral care and counselling.
- Hospices.

Local Delivery Management
- No overall management body, a variety of groups are involved in individual services.
- Can be institutionally based either through in-patient beds or mobile units providing in-home services.
- Often community based.
- Involves interdisciplinary teams of health care workers providing care (eg. visiting nurses, homecare providers, home support service providers).
- Often involves philanthropic organizations.
- Lay caregivers on a voluntary basis; generally family members.

Funding Sources
- Some public programs funded by the Ministry of Health (e.g. Home Care, dedicated beds in some hospitals).
- MCSS funding of home support services and home health aides.
- Philanthropic donors.

Provider/Delivery Arrangements
- Varies with those who deliver services.
- Generally direct service by sponsoring organization except for services provided in the home which are purchased by Home Care programs and Integrated Homemaker Programs.

Linkages to Other Services
- Chronic care units.
- Non-institutional palliative care services involve a wide network of health and social services, including a significant role of pastoral caregivers throughout various religious denominations.

HEALTH PROMOTION AND PREVENTION

Target Clients
- All individuals.
- Specific "at risk" target groups (e.g. smokers, overweight individuals).

Objectives
- Enable individuals to take responsibility for, and to increase control over and improve their health.
- Optimize health status of Ontario's population.
- Avoid and reduce risks to health (e.g. diet).
- Reduce utilization of health care services.
- Enhance the health of the population.
- Achieve system wide reductions in health care expenditures.
- Improved productivity of workers through reduced sick days.
- Encourage a broader responsibility for health and healthy environments.

Range of Services Offered
- Public awareness campaigns sponsored by public health units, provincial and federal governments to:
  - support healthy lifestyles;
  - discourage "at risk" behaviours.
- Enforcement of healthy public policy.
- Voluntary individualized health status assessments.
- Advice and education by some primary health care providers.

Local Delivery Management
- Various voluntary and non-profit groups (e.g. Cancer Society).
- Municipal public health departments.
- Individual employers and health service providers.

Funding Sources
- Federal, provincial and municipal governments including Ministry of Health, Health and Welfare Canada, Attorney General.
- Voluntary associations.

Provider Delivery Arrangments
- Varies depending on activities conducted.

Linkage With Other Services
- Occupational health.
- Public Health.
- Primary care.
- Fitness and recreational services.

OCCUPATIONAL HEALTH

Target Groups
- Individuals in the workplace.
- Employers.

Objectives
- To prevent and avoid accidents or incidents in the workplace which contribute to injury, illness or long term disability of employees.
- Promote safe practices in the workplace.

Range of Services Offered
- Direct provision of primary health care services to workers injured on the job.
- Dissemination of general health promotion and illness prevention materials through literature, in-service training and other means.
- Monitoring and analysis of incident data by the industry associations and the Ministry of Health.

Local Delivery Management
- Individual employers which may have their own occupational health program/division. Can be centrally or locally administered, and provided in-house or on a contract basis.
- Union/management responsibility in unionized companies.

Funding Sources
- A variety of sources including:
  - employers;
  - some subsidization by the provincial government under the terms of Occupational Health and Safety Legislation;
  - OHIP for services provided to injured workers who cannot be treated within the workplace;
  - Workers Compensation Board.

Provider/Delivery Arrangements
- Purchase of service from individual providers (e.g. Industrial Accident Prevention Association, hospitals, occupational health professionals) for direct health services and program development and educational services.
- Directly by employer through in-house staff.
- Labour groups on behalf of bargaining unit for education of employees and monitoring of workplace practices.

Linkages With Other Services
- Inpatient and outpatient medical care (e.g. hospitals, outpatient clinics, rehabilitation centres, HSO's, primary care centres).
- Public health units re: immunization, environmental health.
- Workers Compensation Board.
- Industry Associations.
- Vocational Rehabilitation.

COORDINATION AND REFERRAL SERVICES

Target Clients
- All individuals seeking health or social services or information on services.
- Individuals with multiple service needs (e.g. elderly individuals, physically or mentally disabled persons).

Objectives
- Ensure range of individual service needs are met.
- Avoid duplication of services and inappropriate use of services.
- Minimize burden on individuals seeking services.

Range of Services Offered
- Information.
- Case management.
- Assessment and placement coordination.

Local Delivery Management

- Local Home Care Programs for eligible individuals.
- Local community information centres.
- Placement coordination services (public and private).
- Some hospital discharge planners.
- One-Stop Access pilot projects.

Funding Sources

- Ministry of Health.
- Ministry of Community and Social Services.
- Office for Senior Citizens Affairs.
- Some municipal contributions.

Provider Delivery Arrangements

- Directly by community information centres and services, some discharge planners and placement coordination services.
- Home Care case managers assess needs, develop plans of care, order services for profit and non-profit providers and reassess needs periodically.

Linkages

- Institutional services.
- Speciality services.
- Professional and non-professional home health services.
- Community social services.
- Voluntary, self help groups.

APPENDIX C

LIST OF ATTENDEES

EXPERT PANEL CONFERENCE

HEALTH CARE SYSTEM SUBCOMMITTEE

PREMIER'S COUNCIL ON HEALTH STRATEGY

PREMIER'S COUNCIL MEMBERS AND STAFF

Mr. Roy Aitken
Executive Vice-President, Inco
Chair, Health Care System Subcommittee
Premier's Council on Health Strategy

Mr. John Carter
President, Greater Niagara General Hospital
Member, Health Care System Subcommittee
Premier's Council on Health Strategy

Ms. Eleanor Ross
President, Registered Nurses Association of Ontario
Member, Health Care System Subcommittee
Premier's Council on Health Strategy

Dr. Hugh Scully
Past President, Ontario Medical Association
Cardiovascular Surgeon, Deputy Surgeon in Chief,
Toronto General Hospital
Member, Health Care System Subcommittee
Premier's Council on Health Strategy

Dr. Reva Gerstein, Q.C.
Psychologist
Vice Chair, Board of Trustees, Hospital for Sick Children
Chair, Healthy Public Policy Subcommittee
Premier's Council on Health Strategy

Ms. Mary Shamley
Past Chair, Association of District Health Councils
Chair, Thames Valley District Health Council
Chair, Health Goals Subcommittee
Premier's Council on Health Strategy

Dr. Naomi Rae-Grant
Psychiatrist, Child and Adolescent Services - Victoria Hospital, London, Ontario
Member, Integration and Coordination Subcommittee
Premier's Council on Health Strategy

Dr. Martin Barkin
Deputy Minister of Health
Past President, Sunnybrook Medical Centre
Secretary, Premier's Council on Health Strategy

Ms. Marilyn Knox
Executive Director
Premier's Council on Health Strategy

Mr. Lorne Zon
Manager, Health Innovations
Premier's Council on Health Strategy

Ms. Terry Bisset
Manager, Internal Relations
Premier's Council on Health Strategy

Dr. Jim Shosenberg
Manager, External Relations/Communications
Premier's Council on Health Strategy

INVITED ATTENDEES

Ms. Jennifer Ritchie
Consumer
Toronto, Ontario

Mr. Peter Ellis
President, Sunnybrook Medical Centre
North York, Ontario

Ms. Brenda Singer
Executive Director, Progress Place
Toronto, Ontario

Mr. John Butler
Executive Director, Peel District Health Council
Brampton, Ontario

Mr. Graham Scott
Former Deputy Minister of Health
Partner, McMillan and Binch
Chair, Task Force on the Use and Provision of Medical Services

Mr. Ron Draper
Office of Health Education
World Health Organization
European Regional Officer
Copenhagen, Denmark

Mr. W. Vickery Stoughton
President, The Toronto Hospital
Toronto, Ontario

Dr. Abbyann Lynch
Director, Westminister Institute for Ethics and Human Values
London, Ontario

Dr. Sandy MacPherson
Education Centre for Aging
Hamilton, Ontario

Dr. Nancy Milio
Professor, University of North Carolina
Chapel Hill, North Carolina

Mr. James Callahan
Professor, Heller School
Brandeis University
Waltham, Massachusetts

Ms. Maya Kagis
President, Ontario Association of Health Centres

GOVERNMENT OFFICIALS

Mr. Mike McEwen
Area Planning Coordinator - District Health Council Programs
Ministry Liaison, Health Care System Subcommittee

Mr. Jay Kaufman
Assistant Deputy Minister
Institutional Health
Ministry of Health

Mr. Terry Hewak
Senior Economist
Fiscal Planning Policy Branch
Ministry of Treasury and Economics

Mr. Michael Mendelson
Assistant Deputy Minister
Community Services Division
Ministry of Community and Social Services

Dr. Robert MacMillan
Assistant Deputy Minister
Community Health
Ministry of Health

ALBERTA DELEGATION

Dr. Alex McPherson
Oncologist
Deputy Commissioner
Premier's Commission on Future Health Care for Albertans

Mr. Gene Murrant
Electrical Contractor
Commissioner, Premier's Commission on Future Health Care for Albertans

Dr. Ruth Collins-Nakai
Past President, Alberta Medical Association
Pediatric Cardiologist
Commissioner, Premier's Commission on Future Health Care for Albertans

Ms. Carol Snedden
Commissioner, Premier's Commission on Future Health Care for Albertans

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Mr. Neil Stuart
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Ms. Siobhan Cavanaugh
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Mr. Bill Bain
Stevenson Kellogg Ernst & Whinney

Mr. Ted Gillespie
Stevenson Kellogg Ernst & Whinney

Mr. Tony Culyer
Stevenson Kellogg Ernst & Whinney

Mr. Rowland Hope
Stevenson Kellogg Ernst & Whinney

Dr. Alan Raisbeck
Stevenson Kellogg Ernst & Whinney

Dr. Geoffrey Anderson
Stevenson Kellogg Ernst & Whinney

APPENDIX D

LIST OF INTERVIEWEES

Dr. Peggy Leatt
Professor
Health Administration, University of Toronto

Ms. Judith Wahl
Executive Director
Advocacy Centre for the Elderly

Dr. Michael Rachlis
Physician

Dr. Richard Moulton
Physician
Fort Francis Clinic, Ontario

Ms. Kathy Pegonis
Executive Director
Victorian Order of Nurses, Ontario

Dr. Dorothy Pringle
Dean of Nursing
University of Toronto

Dr. Robert MacMillan
Assistant Deputy Minister
Ontario Ministry of Health

Ms. Sandy Lang
Assistant Deputy Minister
Community Services
Ontario Ministry of Community and Social Services

Mr. Peter Ellis
President
Sunnybrook Medical Centre

Mr. Steve Raiken
Executive Director
Metro Toronto District Health Council

Mr. Mark McGuire
Executive Director
Association of Ontario Health Centres

Ms. Shanthi Radcliffe
Project Coordinator
London Urban Resource Centre

Ms. Lindsay Hall
Executive Director
Flemingdon Health Centre

Ms. Frances Picherack
Director, Policy Analysis
College of Nurses of Ontario

Mr. Alan Schwartz
Lawyer
Fogler Rubinoff Barristers

Dr. Martin Barkin
Deputy Minister of Health
Ontario Ministry of Health

Dr. Raisa Dieber
Professor, Health Administration
University of Toronto

Ms. Peg Folson
President
Ontario Public Health Association

Ms. Maureen Quigley
Trustee, Hospital for Sick Children
Consultant

Ms. Mary Shamley
Reeve
Village of Wardsville

Mr. Roy Aitken
Executive Vice-President
Inco

Father Sean O'Sullivan
Chairman
Review of Advocacy for Vulnerable Adults

Mr. Gordon Cunningham
President
Ontario Hospital Association

Ms. Joan Watson
Consumer Advocate

Dr. Reva Gerstein
Vice Chair
Board of Trustees, Hospital for Sick Children

Mr. Cliff Nordal
President
Queen Elizabeth Hospital

Ms. Giah Eisenstein
Executive Director, Community Health
Ministry of Health